DOCUMENT RESUME

ED 440 329 CG 029 870

TITLE	Substance Abuse Treatment for Persons with Child Abuse and Neglect Issues. Treatment Improvement Protocol (TIP) Series, 36.
INSTITUTION	Substance Abuse and Mental Health Services Administration (DHHS/PHS), Rockville, MD. Center for Substance Abuse Treatment.
REPORT NO	SMA-00-3357
PUB DATE	2000-00-00
NOTE	199p.
CONTRACT	270-95-0013
AVAILABLE FROM	National Clearinghouse for Alcohol and Drug Information, P.O. Box 2345, Rockville, MD 20847-2345. Tel: 301-468-2600; Tel: 800-729-6686 (Toll Free); Tel: 800-487-4889 (TDD); Fax: 301-468-6433.
PUB TYPE	Guides - Non-Classroom (055) -- Information Analyses (070)
EDRS PRICE	MF01/PC08 Plus Postage.
DESCRIPTORS	*Child Abuse; *Child Neglect; Counseling Objectives; *Crisis Intervention; Guidelines; Mental Health Programs; *Parent Counseling; *Substance Abuse

ABSTRACT

This volume of the Treatment Improvement Protocol (TIP) Series examines treatment issues for both adult survivors of child abuse or neglect and adults in treatment who may be abusing or neglecting their own children. Chapters 1 through 3 focus primarily on adult survivors of child abuse and neglect. Chapter 1 defines child abuse and neglect, provides rates of child abuse and neglect both in the general population and among those in substance abuse treatment, and reviews the literature on links between childhood abuse and subsequent substance abuse. Chapter 2 describes screening and assessment tools that can be used to determine whether a client has a history of childhood abuse or neglect. Chapter 3 presents guidelines on treating clients with histories of child abuse or neglect and referring them to mental health care treatment when necessary. Chapter 4 discusses the personal issues counselors may encounter when working with clients with histories of abuse or neglect and offers suggestions for addressing them. In Chapters 5 and 6, the focus shifts to adults in treatment who may be abusing or neglecting their own children. Chapter 5 shows how alcohol and drug counselors can identify whether their clients are at risk of or are currently abusing or neglecting their children. It discusses what alcohol and drug counselors can do to break the cycle of child abuse and neglect, including how to work with child protective service agencies within the child welfare system. Chapter 6 is an overview of the legal issues that counselors should be aware of as mandated reporters. The TIP concludes with an overview in Chapter 7 of continuing and emerging trends that counselors will need to follow in the coming years. (Contains 405 references and 7 appendixes.) (GCP)

Reproductions supplied by EDRS are the best that can be made
from the original document.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Substance Abuse and Mental Health Services Administration

Substance Abuse and Mental Health Services Administration

Center for Substance Abuse Treatment

ED 440 329

Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues

Treatment Improvement Protocol (TIP) Series

36

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
☐ This document has been reproduced as received from the person or organization originating it.
☐ Minor changes have been made to improve reproduction quality.
- Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

BEST COPY AVAILABLE

CG029870

Substance Abusers With Childhood Abuse and Neglect Histories

Research and clinical evidence indicates that physical, sexual, and emotional abuse and neglect during childhood can increase a person's risk of developing substance abuse disorders. The Consensus Panel encourages providers to screen for histories of childhood abuse or neglect in order to understand how such issues might impact a client's substance abuse behavior.

The following questions can be used as part of a screening for histories of childhood abuse or neglect. They can be asked as written. However, they can also be asked in relation to developmental stages. To do so, ask the same question with a different introductory phrase that reflects different time periods or developmental stages. For example, the basic question, "Were you treated harshly as a child?" can be rephrased as, "When you were 5 to 10 years old …" or, "When you were 11 to 15 years old… . "

Questions about traumatic events:

- Were there any significant traumatic events in your family while you were growing up? For example, did any of the following events occur in your family: death of a parent or sibling, hospitalization of a parent or sibling, incarceration of a parent or sibling, divorce, or chronic disease?
- Were you treated harshly as a child?
- Did you ever experience physical, sexual, or emotional abuse as a child?
- Did you experience inappropriate physical or sexual contact with an adult or person at least 5 years older than you while you were growing up?
- When you were a child, was there violence in your household, such as battering of family members involving siblings or a parent and their partner?
- Do you feel that your parents neglected you while you were growing up? For example, were there ever periods during which you did not have adequate food, clothing, shelter, or protection by your parents?
- Did your parents use alcohol or drugs frequently when you were growing up? Did you ever use alcohol or drugs with them?

Questions about circumstances that may suggest traumatic events:

- Have you or anyone in your family ever been involved with the child protective system?
- Did you ever live away from your parents? Were you ever in foster care? Were any of your siblings ever in foster care?
- When you were a child, were there any periods when you felt unsafe or in danger?
- When you were growing up, did anyone in your family abuse alcohol or other drugs? How did their alcohol or other drug abuse affect you as a child?
- Have you ever felt that abuse or neglect was justified based on your misbehavior or shortcomings? (In other words, did the client feel that the abuse was her fault—that she deserved it?)

Parents and Child Abuse

Research also suggests that substance abusers with histories of child abuse and neglect are at greater risk for abusing their own children, who may consequently grow up with substance abuse issues of their own. Unless effective intervention occurs, there is an increased likelihood that patterns of substance abuse and child maltreatment will be repeated in the next generation. A counselor can monitor clients for the following behavioral clues that suggest they may be abusing their own children:

- Name calling, verbal abuse, negative or belittling labeling of the child
- Stories that suggest children are living in unsafe conditions (e.g., spoiled food, being left alone, traveling in unsafe neighborhoods)
- Blaming children or directing misplaced anger on them that may mask guilt about poor parenting
- Describing children inappropriately in terms of their development (e.g., having expectations for a 4-year-old that should be reserved for a 12-year-old)
- Giving children too much responsibility and autonomy for their age
- Sexualizing the child
- Insisting that the child is just like one of the parents (i.e., negatively describing him)
- Negative attitudes or poor treatment (e.g., criticizing the child) from the caregiver's partner
- Inappropriate disciplinary measures; an inability to distinguish between discipline (guiding) and punishment (hurting)

Substance Abuse Treatment for Persons With Child Abuse And Neglect Issues

Treatment Improvement Protocol (TIP) Series

36

Judy Howard, M.D.

Consensus Panel Chair

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment

Rockwall II, 5600 Fishers Lane
Rockville, MD 20857

This publication is part of the Substance Abuse Prevention and Treatment Block Grant technical assistance program. All material appearing in this volume except that taken directly from copyrighted sources is in the public domain and may be reproduced or copied without permission from the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) or the authors. Citation of the source is appreciated.

This publication was written under contract number 270-95-0013 with The CDM Group, Inc. (CDM). Sandra Clunies, M.S., I.C.A.D.C., served as the CSAT government project officer. Rose M. Urban, L.C.S.W., J.D., C.C.A.S., served as the CDM TIPs project director. Other CDM TIPs personnel included Raquel Ingraham, M.S., project manager; Jonathan Max Gilbert, M.A., managing editor; Cara Smith, production editor; Kurt S. Olsson, former editor/writer; Paul Seaman, former acting editor; Y-Lang Nguyen, former production editor; and MaryLou Leonard, former project manager. Special thanks go to consulting writers Tracy Simpson, Ph.D., and Christine Courtois, Ph.D., for their considerable contributions to this document.

The opinions expressed herein are the views of the Consensus Panel members and do not reflect the official position of CSAT, SAMHSA, or the U.S. Department of Health and Human Services (DHHS). No official support or endorsement of CSAT, SAMHSA, or DHHS for these opinions or for particular instruments or software that may be described in this document is intended or should be inferred. The guidelines proffered in this document should not be considered as substitutes for individualized client care and treatment decisions.

DHHS Publication No. (SMA) 00-3357
Printed 2000

Contents

What Is a TIP? vii

Editorial Advisory Board ix

Consensus Panel xi

Foreword xiii

Executive Summary and Recommendations xv

Recommendations xvi

Chapter 1—Working With Child Abuse and Neglect Issues 1

Substance Abuse and Child Abuse and Neglect 2
Implications for Treatment of Clients With Child Abuse Histories 4
Incidence of Child Abuse and Neglect 8
Incidence of Child Abuse and Neglect Histories Among Adults 9
Defining Abuse and Neglect 9

Chapter 2—Screening and Assessing Adults for Childhood Abuse and Neglect 15

Challenges to Accurate Screening and Assessment 16
Screening for a History of Child Abuse or Neglect 20
Formal Assessment for a History of Child Abuse or Neglect 25
Special Considerations and Recommendations 39

Chapter 3—Comprehensive Treatment for Adult Survivors of Child Abuse and Neglect 43

Treatment Issues 44
Treatment Techniques 50

Chapter 4—Therapeutic Issues for Counselors 61

Transference, Countertransference, and Secondary Traumatization 61
Establishing the Treatment Frame and Special Issues 64
Responsibility of the Agency To Support the Counselor 70

Chapter 5—Breaking the Cycle: The Substance-Dependent Client as Parent/Caregiver 73

Who Abuses and Why 74

Role of the Counselor ... 76
Clues That the Client May Be Endangering Children ... 79
Incorporating Treatment Strategies for Child Abusers ... 79
Organizational Roles and the Need for Collaboration ... 88

Chapter 6—Legal Responsibilities and Recourse ... 95

Mandated Reporting ... 96
State Laws Regarding Child Abuse and Neglect ... 100
CPS Agency Investigation and Potential Outcomes ... 104

Chapter 7—Emerging and Continuing Issues ... 115

The Impact of New Legislation on Parents in Treatment ... 115
Emerging Issues ... 117
Continuing Trends ... 121

Appendix A—Bibliography ... 125

Appendix B—Protecting Clients' Privacy ... 151

The Federal Confidentiality Law and Regulations ... 151
Rules for Obtaining Client Consent To Disclose Treatment Information ... 152
Rules for Communicating With CPS Agencies and Others About Clients ... 155
Other Exceptions to the General Rule ... 157
Other Rules About Clients' Right to Confidentiality ... 162
Conclusion ... 163

Appendix C—Implications of Recent Federal Legislation for Clients in Treatment ... 165

Welfare Reform ... 165
Family Preservation and "Fast-Track Adoption" ... 166

Appendix D—Obtaining Screening and Assessment Tools ... 169

Appendix E—Resources Related to Childhood Trauma Among Adults ... 173

Associations and Societies ... 173
Organizations and Clearinghouses ... 174
Publications ... 176

Appendix F—Resource Panelists ... 177

Appendix G—Field Reviewers ... 179

Figures

2-1 Symptoms and Syndromes Associated With Childhood Abuse and Neglect ... 18
2-2 Direct Questions To Screen for a History of Childhood Abuse or Neglect ... 24
2-3 Common Responses to Childhood Trauma Among Adults ... 31
5-1 Behavioral Clues That Suggest Possible Child Abuse or Neglect ... 80
5-2 Strategies for Collaboration ... 89

5-3 Overview of Steps Through the Child Protective Services and Child Welfare Systems 91
6-1 Reporting Child Abuse and Neglect: Sources of Advice in Difficult Cases 98
7-1 Linking Child Welfare and Substance Abuse Treatment Systems 121
B-1 Sample Consent Form 154
B-2 Consent Form: Criminal Justice System Referral 158
B-3 Qualified Service Organization Agreement 161

What Is a TIP?

Treatment Improvement Protocols (TIPs) are best practice guidelines for the treatment of substance abuse, provided as a service of the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment (CSAT). CSAT's Office of Evaluation, Scientific Analysis and Synthesis draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPs, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPs is expanding beyond public and private substance abuse treatment facilities as alcoholism and other substance abuse disorders are increasingly recognized as major problems.

The TIPs Editorial Advisory Board, a distinguished group of substance abuse experts and professionals in such related fields as primary care, mental health, and social services, works with the State Alcohol and Other Drug Abuse Directors to generate topics for the TIPs based on the field's current needs for information and guidance.

After selecting a topic, CSAT invites staff from pertinent Federal agencies and national organizations to a Resource Panel that recommends specific areas of focus as well as resources that should be considered in developing the content of the TIP. Then recommendations are communicated to a Consensus Panel composed of non-Federal experts on the topic who have been nominated by their peers. This Panel participates in a series of discussions; the information and recommendations on which they reach consensus form the foundation of the TIP. The members of each Consensus Panel represent substance abuse treatment programs, hospitals, community health centers, counseling programs, criminal justice and child welfare agencies, and private practitioners. A Panel Chair (or Co-Chairs) ensures that the guidelines mirror the results of the group's collaboration.

A large and diverse group of experts closely reviews the draft document. Once the changes recommended by these field reviewers have been incorporated, the TIP is prepared for publication, in print and online. The TIPs can be accessed via the Internet on the National Library of Medicine's home page at the URL: http://text.nlm.nih.gov. The move to electronic media also means that the TIPs can be updated more easily so they continue to provide the field with state-of-the-art information.

Although each TIP strives to include an evidence base for the practices it recommends, CSAT recognizes that the field of substance abuse treatment is evolving and that research frequently lags behind the innovations pioneered in the field. A major goal of each TIP is to convey "front line" information quickly but responsibly. For this reason, recommendations proffered in the TIP are attributed to either Panelists' clinical experience or the literature. If there is research to support a particular approach, citations are provided.

This TIP, *Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues,* examines treatment issues for both adult survivors of child abuse or neglect and adults in treatment who may be abusing or neglecting their own children.

Chapters 1 through 3 focus primarily on adult survivors of child abuse and neglect. Chapter 1 defines child abuse and neglect, provides rates of child abuse and neglect both in the general population and among those in substance abuse treatment, and reviews the literature on links between childhood abuse and subsequent substance abuse. Chapter 2 describes screening and assessment tools that can be used to determine whether a client has a history of childhood abuse or neglect; Chapter 3 presents guidelines on treating clients with histories of child abuse or neglect and referring them to mental health care treatment when necessary. Chapter 4 discusses the personal issues counselors may encounter (e.g., countertransference) when working with clients with histories of abuse or neglect and offers suggestions for addressing them.

In Chapters 5 and 6, the focus shifts to adults in treatment who may be abusing or neglecting their own children. Chapter 5 shows how alcohol and drug counselors can identify whether their clients are at risk of or are currently abusing or neglecting their children. It discusses what alcohol and drug counselors can do to break the cycle of child abuse and neglect, including how to work with child protective service agencies within the child welfare system. Chapter 6 is an overview of the legal issues that counselors should be aware of as mandated reporters. The TIP concludes with an overview in Chapter 7 of continuing and emerging trends, such as fast-track adoption and welfare reform, that counselors will need to follow in the coming years.

Other TIPs may be ordered by contacting SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI), (800) 729-6686 or (301) 468-2600; TDD (for hearing impaired), (800) 487-4889.

Editorial Advisory Board

Karen Allen, Ph.D., R.N., C.A.R.N.
Professor and Chair
Department of Nursing
Andrews University
Berrien Springs, Michigan

Richard L. Brown, M.D., M.P.H.
Associate Professor
Department of Family Medicine
University of Wisconsin School of Medicine
Madison, Wisconsin

Dorynne Czechowicz, M.D.
Associate Director
Medical/Professional Affairs
Treatment Research Branch
Division of Clinical and Services Research
National Institute on Drug Abuse
Rockville, Maryland

Linda S. Foley, M.A.
Former Director
Project for Addiction Counselor Training
National Association of State Alcohol and Drug Abuse Directors
Washington, D.C.

Wayde A. Glover, M.I.S., N.C.A.C. II
Director
Commonwealth Addictions Consultants and Trainers
Richmond, Virginia

Pedro J. Greer, M.D.
Assistant Dean for Homeless Education
University of Miami School of Medicine
Miami, Florida

Thomas W. Hester, M.D.
Former State Director
Substance Abuse Services
Division of Mental Health, Mental Retardation and Substance Abuse
Georgia Department of Human Resources
Atlanta, Georgia

James G. (Gil) Hill, Ph.D.
Director
Office of Substance Abuse
American Psychological Association
Washington, D.C.

Douglas B. Kamerow, M.D., M.P.H.
Director
Office of the Forum for Quality and Effectiveness in Health Care
Agency for Health Care Policy and Research
Rockville, Maryland

Stephen W. Long
Director
Office of Policy Analysis
National Institute on Alcohol Abuse and Alcoholism
Rockville, Maryland

Richard A. Rawson, Ph.D.
  Executive Director
  Matrix Center and Matrix Institute on Addiction
  Deputy Director, UCLA Addiction Medicine Services
  Los Angeles, California

Ellen A. Renz, Ph.D.
  Former Vice President of Clinical Systems
  MEDCO Behavioral Care Corporation
  Kamuela, Hawaii

Richard K. Ries, M.D.
  Director and Associate Professor
  Outpatient Mental Health Services and Dual Disorder Programs
  Harborview Medical Center
  Seattle, Washington

Sidney H. Schnoll, M.D., Ph.D.
  Chairman
  Division of Substance Abuse Medicine
  Medical College of Virginia
  Richmond, Virginia

Consensus Panel

Chair

Judy Howard, M.D.
Professor of Pediatrics
Developmental Studies Program
Department of Pediatrics
School of Medicine
University of California at Los Angeles
Los Angeles, California

Workgroup Leaders

Lynn Dorman, Ph.D., J.D.
Brattleboro, Vermont

David Duncan, Dr.P.H., C.A.S.
Associate Professor
Center for Alcohol and Addiction Studies
Brown University
Providence, Rhode Island

Jerry P. Flanzer, D.S.W., L.C.S.W., C.A.C.
Director
Recovery and Family Treatment, Inc.
Alexandria, Virginia

Marie Littlejohn, M.S.W., C.S.W.
Director of Social Work
Maternity Infant Care
Medical and Health Research Association
New York, New York

Joan E. Massaquoi, M.S.W., L.C.S.W., B.C.D.
Chicago, Illinois

Thomas J. McMahon, Ph.D.
Assistant Professor of Psychology
Substance Abuse Center
Yale School of Medicine
New Haven, Connecticut

Panelists

Sarah A. Addlesberger
Program Coordinator
Castle Medical Center
Ocean View, Hawaii

Christian A. Akiwowo, Ph.D.
President/Chief Executive Officer
Alajobi Rehabilitative Services
Olympia Fields, Illinois

Darlene Allen, M.S.
Director
Child Welfare Services
Children's Friend and Services
Providence, Rhode Island

Michael D. De Bellis, M.D.
Assistant Professor of Psychiatry
Developmental Traumatology Laboratory
University of Pittsburgh Medical Center
Pittsburgh, Pennsylvania

Pamela L. Donaldson, A.R.N.P-C., C.A.R.N, Ph.D.
Post-Doctoral Fellow
New York State Psychiatric Institute
Columbia University
Hackensack, New Jersey

James Herrera, M.A., L.P.C.C.
Center on Alcoholism, Substance Abuse and Addictions
University of New Mexico
Albuquerque, New Mexico

Margo H. Juarez, L.A.D.A.C., R.I.M.H.C.
Albuquerque Metropolitan Central Intake
Albuquerque, New Mexico

Lewis Jay Lester, M.S.W., L.C.S.W.
Briceland, California

Herschel Swinger, Ph.D.
Children's Institute International
Los Angeles, California

14

Foreword

The Treatment Improvement Protocol (TIP) series fulfills SAMHSA/CSAT's mission to improve treatment of substance abuse by providing best practices guidance to clinicians, program administrators, and payors. TIPs are the result of careful consideration of all relevant clinical and health services research findings, demonstration experience, and implementation requirements. A panel of non-Federal clinical researchers, clinicians, program administrators, and client advocates debates and discusses their particular area of expertise until they reach a consensus on best practices. This panel's work is then reviewed and critiqued by field reviewers.

The talent, dedication, and hard work that TIPs panelists and reviewers bring to this highly participatory process have bridged the gap between the promise of research and the needs of practicing clinicians and administrators. We are grateful to all who have joined with us to contribute to advances in the substance abuse treatment field.

Nelba Chavez, Ph.D.
Administrator
Substance Abuse and Mental Health
Services Administration

H. Westley Clark, M.D., J.D., M.P.H.,
CAS, FASAM
Director
Center for Substance Abuse Treatment
Substance Abuse and Mental Health
Services Administration

Executive Summary and Recommendations

Child abuse and neglect pose an increasingly recognized and serious threat to the nation's children. The reported cases of abused and neglected children have more than doubled from 1.4 million in 1986 to more than 3 million in 1997. Research suggests that adults with histories of child abuse and neglect are at high risk for developing substance abuse disorders. Moreover, these childhood abuse and neglect issues may negatively affect clients' chances for recovery from substance abuse. Compounded with these problems is the increased likelihood of substance-abusing parents abusing their own children. By most accounts, substance abuse contributes to almost three fourths of the incidents of child abuse or neglect for children in foster care.

Two major reports released in 1999 highlight the need to address this intergenerational cycle of substance abuse and child abuse if effective progress is to be made on either problem. These studies are *Blending Perspectives and Building Common Ground: A Report to Congress on Substance Abuse and Child Protection* by the U.S. Department of Health and Human Services (DHHS) and *No Safe Haven: Children of Substance-Abusing Parents* by the National Center on Addiction and Substance Abuse (CASA) at Columbia University. Both reports emphasize that the rise in substance abuse as a factor in child abuse and neglect cases has severely complicated efforts by child welfare systems to protect children and rehabilitate families. In response to these issues, this Treatment Improvement Protocol (TIP) presents information to assist alcohol and drug counselors and other treatment providers to work more effectively with adults who have histories of childhood abuse or neglect and adults who abuse or who are at risk for abusing their own children.

The effects of childhood abuse and neglect perpetrated by family members and the intergenerational transmission of the cycle of substance abuse and child abuse and neglect are the focus of this TIP. However, not all clients in treatment have a history of childhood abuse, not all children who are maltreated become substance abusers or child abusers, and not all child abusers have a history of childhood abuse or current substance abuse. Although these are common factors that often arise in substance abuse treatment, they are not present in every case.

This TIP does not address the treatment needs of children who are currently being abused, as that area of concern is extensively addressed in multidisciplinary literature. This TIP also does not address children who are abusing substances, many of whom may have experienced abuse and neglect. The issues involved in treating children and adolescents for substance abuse differ greatly from those encountered with an adult client population. Guidelines for screening, assessing, and treating adolescents with substance abuse disorders are offered in TIP 31, *Screening and Assessment of Adolescents for Substance Use Disorders* (CSAT, 1999a), and TIP 32, *Treatment of Adolescents With Substance Use Disorders* (CSAT, 1999b). A third group not addressed here is pedophiles. The Consensus Panel considers pedophilia to be a separate category of child sexual abuse beyond the scope of this document. The most pervasive form of child maltreatment is neglect (60 percent); however, because most research has focused on childhood physical and sexual abuse, this TIP will primarily address these two forms.

Definitions of the types of behaviors and specific acts that constitute physical, emotional, and sexual abuse and neglect are provided in Chapter 1 so that counselors can better understand the range of potential experiences of their clients. In Chapter 2, the TIP discusses common signs and behaviors that suggest a history of childhood emotional, physical, and sexual abuse and neglect, as well as indicators that clients might be abusing their own children. Chapter 3 addresses the distinct treatment issues that counselors may encounter in working with adults who have been abused or neglected in childhood. Among the factors that can complicate treatment for this population are comorbid mental disorders and trauma-related symptoms.

Because of the abhorrent nature of child abuse and the emotional difficulty of working with traumatized individuals and with individuals who harm children, personal issues for counselors are discussed throughout this TIP and are the focus of Chapter 4. Substance-abusing parents who may be abusing or neglecting their children are the subject of Chapter 5. In working with child abusers, many of whom are ordered into treatment by the courts, treatment counselors must understand the structure of the child protective services (CPS) system and the family and criminal courts in order to help clients negotiate these systems. The TIP provides some guidelines for communicating with these systems; however, treatment providers must learn the particulars of how these services are structured in their State and local jurisdictions. Chapter 6 discusses the relevant laws on reporting current child abuse and maintaining client confidentiality; recent legislation on family preservation, fast-track adoption, and reunification laws are reviewed in Chapter 7.

Throughout this TIP, the term "substance abuse" has been used in a general sense to cover both substance abuse disorders and substance dependence disorders (as defined by the *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition [DSM-IV] American Psychiatric Association, 1994). Because the term "substance abuse" is commonly used by substance abuse treatment professionals to describe any excessive use of addictive substances, in this TIP it will be used to denote both substance dependence and substance abuse disorders. The term relates to the use of alcohol as well as other substances of abuse. Readers should attend to the context in which the term occurs in order to determine what possible range of meanings it covers; in most cases, however, the term will refer to all varieties of substance use disorders as described by DSM-IV.

To avoid both sexism and awkward sentence construction, the TIP alternates between the pronouns "he" and "she" in generic examples.

Recommendations

The Consensus Panel's recommendations, summarized below, are based on both research and clinical experience. Those supported by scientific evidence are followed by (1); clinically based recommendations are marked (2). Citations to the former are referenced in the body of this document, where the guidelines are presented in detail.

The Consensus Panel recommends that, when working with clients with substance abuse problems and histories of childhood abuse and neglect, counselors adopt a broad approach that considers the meaning of the experience to the client, not just legal definitions of child abuse and neglect. (1) Counselors must, therefore, understand how clients interpret their experiences. Not all abuse meets the legal or commonly held criteria for abuse, nor do all clients perceive as abusive behavior that which might be legally defined as "abuse."

Screening and Assessment

Without proper screening and assessment, treatment providers may wrongly attribute symptoms of childhood trauma-related disorders to consequences of current substance abuse. Comprehensive screening for root causes of clients' presenting symptoms may greatly increase the effectiveness of treatment. However, counselors face many challenges when screening for and assessing childhood abuse or neglect. Many abuse survivors are ashamed of having been victims of childhood physical, emotional, or sexual abuse and may believe that the abuse was self-induced. Screening and assessment, therefore, should be designed to reduce the threat of humiliation and blame and should be done in a safe, nonthreatening environment. (2)

While conducting screenings and assessments, counselors should be mindful that adult survivors of childhood trauma commonly suppress memories of certain traumatic events or minimize their symptoms, either intentionally or unintentionally. Moreover, issues of confidentiality, mandated reporting, and trust may influence the responses to interviews and questionnaires by making some clients less inclined to reveal personal histories of abuse or neglect. Given the variable reliability of clients' responses, counselors should neither overemphasize nor overvalue the role of standardized instruments.

Counselor issues

Counselors who will be screening for and assessing histories of child abuse or neglect should receive specific training in these areas. (2) Although there are no rigid rules regarding who should conduct screenings, having certain skills will increase the likelihood that the screening process is conducted appropriately. Staff members should have an understanding of the types of psychiatric disorders and symptoms that are commonly associated with histories of childhood abuse and neglect.

Counselors who conduct screenings will be prompting clients to recall painful and traumatic events. The reemergence of painful memories may cause intense reactions from clients. Treatment staff should be sensitive to this and prepare for the interview in the following ways:

- Inform clients that talking about such issues might create discomfort; clients should be given a choice to disclose such information, being aware of the possible aftermath. (2)
- Have proper supervision and support mechanisms in place for clients in case a crisis occurs following disclosure (e.g., accessibility to mental health practitioners or medical personnel). (2)
- Assess the sources of social and emotional support available to clients when they return home. (2)

There are many potential barriers to successful screenings and assessments of childhood trauma. To reduce some of these barriers, the Consensus Panel recommends the following:

- Be sensitive to cultural concerns. (1)
- Recognize potential language differences. (2)
- Become aware of gender issues. (2)
- Be nonjudgmental and sensitive. (1)

If counselors experience intense discomfort and anxiety when conducting screenings and assessments, the Consensus Panel recommends that they receive guidance and support from a clinical supervisor and consider whether they could benefit from therapeutic assistance to explore the reasons for their discomfort. (2) A variety of instruments for screening and assessment are discussed in Chapter 2.

Screening

The Consensus Panel suggests screening for child abuse and neglect histories early in the assessment process to identify individuals who exhibit signs and symptoms associated with child abuse and neglect (such as posttraumatic stress disorder [PTSD], major depression, or mood disorders) and to identify those who may benefit from a comprehensive clinical assessment. (2) Screenings should also be conducted at different times throughout the treatment process. Repeated screenings help elicit information about these traumatic experiences—especially after trust has been established in the therapeutic relationship. (2) To conduct a screening effectively, treatment staff should

- Learn and understand ways in which childhood abuse and neglect can affect adult feelings and behaviors. (2)
- Identify those individuals who appear to exhibit these symptoms. (2)
- Identify the trauma-related treatment needs of these clients. (2)
- Provide or coordinate appropriate treatment services that will help meet clients' treatment needs. (2)

Screening for childhood abuse or neglect can set in motion a proactive plan with the following benefits:

- *Stopping the cycle.* Although not all adults who were abused or neglected during childhood abuse their own children, they are at greater risk for doing so. (1)
- *Decreasing the probability of relapse.* Many substance abusers consume substances to self-medicate posttraumatic stress symptoms related to past physical or sexual abuse or trauma. (1)
- *Improving a client's overall psychological and interpersonal functioning.* Childhood sexual abuse and neglect may affect the individual's self-concept, sense of self-esteem, and ability to self-actualize. (2)
- *Improving program outcome.* Screening for a history of child abuse or neglect will help a program to determine the needs of its clients, thus improving treatment outcomes. (2)

Assessments

The primary purpose of an assessment is to confirm or discount a positive screening for childhood abuse or neglect, as well as to identify clients' needs so that treatment can be tailored to meet them. The more clinical information a program has about clients' particular treatment needs, the better the program can accommodate them. All clients who screen positive for a history of childhood abuse or neglect should be offered a comprehensive mental health assessment. (2) There is no standard trauma-oriented assessment tool, and no single tool can be considered truly comprehensive. Rather, wisely selected, each of these tools can be a valuable component of a comprehensive assessment process.

When deciding whether to conduct assessments for a history of child abuse or neglect, the treatment team should evaluate clients'

- Current substance use or quality and length of abstinence
- Commitment to the treatment and recovery process
- Risk of relapse

The Consensus Panel believes that treatment decisions and activities are best conducted within the context of a multidisciplinary treatment team, with members having special knowledge in such areas as mental health, child abuse and neglect, and family counseling. (2) Each member of the treatment team should help decide if and when to conduct assessments for childhood trauma, and clients should be asked to evaluate their own readiness to confront child abuse or neglect issues.

Trauma-related assessments are important because they can help the treatment staff understand the types of childhood traumatic events experienced by clients, their subjective response and perceptions of these events, and common current symptoms that may result from childhood trauma. Decisions regarding the types of instruments to use should be influenced by the purpose of the assessment, the setting of the assessment, the population being treated, and the individual client and the severity of his problems. (2)

Assessing histories of childhood trauma can provoke or exacerbate a psychological emergency that must be addressed; therefore the Consensus Panel recommends that the treatment team include a licensed mental health professional to handle medical issues that may arise and to conduct more formal assessments that may be required.

Subjective experience of the events

How clients remember traumatic events can shape their psychological response more than the actual circumstances can; counselors, therefore, need to obtain subjective information about these events. Such information is necessary in order to plan appropriate treatment. Information that should be obtained includes:

- What the client thought about during the abuse
- What the client felt during the abuse
- How the client understood, as a child, what was happening to her and what she thinks about it now
- How the client thinks and feels about how the abuse has affected his adulthood and substance abuse, and how he deals with the aftereffects of the abuse now
- The feelings most closely associated with the abuse experience
- The client's memories of the abuse
- The unique aspects of the client's perceptions about the abuse
- The client's coping strategies, and their effectiveness for the client

Childhood symptoms and family characteristics

The assessment should inquire about childhood symptoms and family characteristics that are consistent with and suggest a history of childhood abuse or neglect. (2) Symptoms to look for include

- Depression (including thoughts of death, passive suicidal ideation, and feelings of hopelessness)
- Dissociative responses during childhood
- Aggressive behavior or other "acting out," including
    - Early sexual activity or sexualized behavior
    - Physically abusing or harming pets or other animals
    - Other destructive behaviors
- Poor relationships with one or both parents
- Attachment disorder, difficulty trusting others
- Excessive passivity
- Passive/aggressive behavior
- Inappropriate age/sexuality formation
- Blacked-out timeframes during childhood
- Excessive nightmares, extreme fear of the dark, or requested locks on doors

Family-of-origin characteristics to consider include

- Parental substance abuse
- Battering within the family
- Involvement with CPS agencies or foster care
- Placement with foster parents or relatives
- Severe discipline during childhood
- Traumatic separations and losses

Treatment Planning

A very important factor in predicting treatment success is the number of services clients receive (e.g., case management, parenting education, counseling for PTSD and childhood abuse). (1) Clients receiving more specialized services, often concurrently with substance abuse treatment, are more likely to stay in recovery. (1) Treatment planning for clients with childhood abuse histories should be a dynamic process that can change as new information is uncovered, taking into account where a client is in the treatment process (e.g., confronting abuse issues too early in treatment can lead to relapse). (2)

However, it is also important for counselors to remember that until some degree of sobriety is achieved, a client's sense of reality is likely to be distorted and her judgment poor. When disclosures of past abuse take place before a client has achieved sobriety, information on childhood abuse and neglect should be heeded, but full exploration of the issue should be postponed until later. (2) Listed below are general recommendations and guidelines counselors should be aware of when planning a client's treatment.

- Counselors should exhibit unconditional positive regard, a nonjudgmental attitude, and sincerity—therapist characteristics that are essential for effective treatment, regardless of therapeutic modality. (1)
- Providers must be sensitive to their clients' cultural issues and how they interact with clients' child abuse or neglect history. The Consensus Panel strongly urges alcohol and drug counselors to be aware of how clients' backgrounds may affect treatment. (2)
- Sympathetic listening can be an important first step in helping a formerly abused client begin the healing process. (2)
- In the initial crisis that often follows a disclosure, the counselor's most important task may be affect management, such as keeping the client calmer by using relaxation techniques. (2)
- Clients who suffered severe childhood abuse may need to be reassured that they are in a safe environment and will not be abused in the present. They may also have to be taught techniques to stay focused in the present. (2)
- Some clients may require medical supervision in inpatient or intensive outpatient programs (at least during the early stages of abstinence) in order to deal with their feelings of rage, anxiety, depression, or suicidality. (2)
- Clients with past trauma should be reassured in treatment that they have the capacity to deal with traumatic memories or related destructive behaviors stemming from childhood abuse. (2)
- Counselors must carefully pace the client's treatment by monitoring anxiety and depression levels and by taking other cues directly from the client. (2)
- Counselors need to isolate the symptoms of substance abuse disorders caused by trauma due to childhood abuse. (2)
- Counselors should search for and apply any available leverage to help clients endure the short-term pain—until some treatment benefits can be realized. Clients must be engaged in a way that will give them hope and increase their beliefs in their own power to create a new life. (2)
- For clients entering substance abuse treatment, the mere act of completing a

questionnaire acknowledging a history of abuse can be tremendously healing and can lead to change, even without the intervention of a counselor. For other clients, however, actively confronting the fact of childhood abuse may be highly disturbing, and counselors must be prepared to respond supportively. (2)

- In acknowledging the client's history of childhood abuse and neglect, the counselor must validate the client's experience by recognizing the issue, refocusing the treatment, and addressing the issue. (2)
- The counselor can help the client develop interpersonal skills through modeling behavior, by empathizing and respecting the client, and by setting boundaries. (2)
- For victims of abuse, the process of reattaching—or attaching for the first time—to other individuals, to a community, or to a spiritual power has tremendous therapeutic value. (2)
- Linkages between substance abuse treatment and mental health agencies are important if the two programs are to understand each other's activities. In the interest of the client, a case summary should be developed that includes the key issues that should be addressed in the next program. (2)
- When symptoms indicate mental health problems that are beyond the scope of the counselor's ability to treat, a referral is clearly warranted. Suicidal thoughts, attempts at self-mutilation, extreme dissociative reactions, and major depression should be treated by a mental health professional, although that treatment may be concurrent with substance abuse treatment. (2)
- Counselors should prepare clients for mental health treatment by helping them realize
  - That their history of childhood abuse or neglect has contributed to some of their errors in thinking, behavior, and decisionmaking
  - That they self-medicated with substances in order to avoid dealing with emotions
  - That they are not alone and that there are resources to help (2)
- Working with at-risk clients in today's litigious climate requires counselors to adhere closely to the accepted standards and ethics of practice as well as the legal requirements of their position. Creating a multidisciplinary team and using proper supervision will help ensure that the counselor maintains such standards. (2)
- Substance abuse counselors always must evaluate the appropriateness of including childhood abuse and neglect survivors in group therapy for other clients in substance abuse treatment. Abuse survivors may not be able to handle the group process until they are able to deal effectively with their attachment issues. (2)
- It is a delicate matter to discuss past abuse in the presence of family members who participated in or were present during it. When such a decision is made, the counselor must bear in mind that *he does not, and should not, have the role of confronting the perpetrator or perpetrators.* (2)

Therapeutic Issues for Counselors

It is inevitable that the counselor will react to the client in ways that are not completely objective. Working with this population may evoke powerful feelings in the counselor. It is important that counselors be aware of and manage their own countertransference reactions and seek supervision as necessary. The Consensus Panel offers the following suggestions to help counselors deal with personal issues when working with clients with childhood abuse and neglect histories.

- In order to teach and model appropriate and healthy interactions, counselors should establish and maintain clear and consistent boundaries with their clients. Adult survivors of child abuse or neglect often need a great deal of affection and approval, and counselors must make clear to the client that they are not responsible for directly meeting all those needs. (2)

- Counselors should focus on empowering the client, recognizing that getting overinvolved will rob clients of the opportunity to draw on their own inner resources. (2)
- Clients' previous experiences may cause them to be mistrustful and suspicious of others, including the counselor. To facilitate the development of a trusting relationship, the counselor should not personalize negative responses but be open, consistent, and nonjudgmental whenever interacting with the client. (2)
- The level of violence and cruelty in disclosures about childhood victimization and exploitation may be very disturbing to counselors. When counselors find themselves manifesting symptoms of anxiety or depression, they should seek direction and support through supervision or peer support. (2)
- Counselors must recognize their personal and professional limitations and not attempt to work with abused clients if they lack the clinical expertise or are not able to manage their own countertransference reactions. (2)
- Burnout, or secondary trauma responses, affects many counselors and can shorten their effective professional life. If counselors meet with a large number of clients (many with trauma histories), do not get adequate support or supervision, do not closely monitor their reactions to clients, and do not maintain healthy personal lifestyles, counseling work of this sort may put them at personal risk. To minimize the likelihood of burnout, counselors should not work in isolation and should seek to treat a caseload of individuals with a variety of problems, not only those who have experienced childhood trauma. (1)
- Alcohol and drug counselors are often subject to great stress. They can be expected to function well and provide effective treatment only if their agency gives them the appropriate support. The agency's leadership should strive to impart a sense of vision to staff members that communicates how important their work is as part of the larger effort to break the cycle of abuse and neglect and its impact on society. (2)

Breaking the Cycle

While many adults with substance abuse disorders do not abuse their own children, they are at increased risk of doing so. When children who are victims of maltreatment become adults, they often lack mature characteristics: the ability to trust, to make healthy partner choices, to manage stress constructively, and to nurture themselves and others. Adults with child abuse histories are then more likely than the general population to develop substance abuse disorders. This intergenerational cycle of substance abuse and child abuse and neglect reflects both the direct and indirect relationship between parental substance abuse and family dynamics, child and adult maltreatment, and second-generation substance abuse. Unless effective intervention occurs, there is an increased likelihood that these patterns will be repeated in future generations. The following list offers recommendations to address this cycle.

- Interventions aimed at breaking the cycle of substance abuse, child neglect, and maltreatment are more successful when they are family centered. (1)
- Counselors can elicit information on a client's childhood experience, which can be useful in predicting the nature of current family relationships. (2)

- Just as counselors can expect that substance-abusing parents often will deny their drug use, they can also expect parents to deny neglecting or abusing their children. Counselors should help parents understand that their parenting behaviors may not be appropriate and that these behaviors can negatively influence their children's future development, especially their ability to trust others and to develop self-esteem and pride. (1)
- Counselors should remember to articulate the positive aspects of clients' lives. (1) Focusing only on the negative or risk factors results in shame and a sense of futility and is counterproductive. Increasing clients' self-esteem and self-efficacy (their effectiveness and ability to take responsibility) is a primary step to acceptance of the child-rearing role.

In addition, it is critical that counselors be able to distinguish between actual cases of child abuse and neglect and situations that arise due to cultural differences, poverty, and lack of education. Providers who work with clients from different cultures should try to develop an understanding of that culture's norms concerning child rearing and discipline.

Legal Issues

Because many parents who abuse substances also neglect or abuse their children, it is common for clients in substance abuse treatment to have some involvement with the CPS system. Some substance-abusing parents will be drawn into the CPS system during treatment; others will be compelled into substance abuse treatment by a CPS agency. In either case, it is critical that treatment providers become familiar with the laws governing the CPS system, including

- How child abuse and neglect are defined in their State
- Whether, when, and how a counselor must report a parent or other primary caretaker—or a parent who was maltreated in childhood—to a CPS agency or police
- What happens after a report is made
- How State-mandated family preservation services operate

Although inappropriate child-rearing practices should be addressed in treatment, they may not, in and of themselves, constitute grounds for an abuse or neglect report. However, if counselors have a reasonable suspicion or firm belief that abuse or neglect has occurred, they are required to make a report. (2) It is important for counselors to bear in mind that a parent who abuses substances is not able to adequately supervise a child and, unless other adults are known to be caring for the child, the counselor should alert the CPS agency regarding potential neglect. It will then be the CPS agency's responsibility to decide whether or not to investigate the matter. (2)

Clients should be informed about the mandatory reporting laws at the time of admission and provided with written documentation regarding both the Federal regulations regarding confidentiality and the counselors' duty to report suspected abuse or neglect. The Consensus Panel recommends that the client be required to acknowledge receipt of such notice in writing. (1)

Counselors are usually not under any obligation to report childhood abuse experienced by an adult client many years ago. However, if the known perpetrator now has custody of—or access to—other children, the program should seek advice about its responsibility to report potential abuse or neglect. (2)

Programs should ask staff members who are mandated reporters to consult a supervisor or team leader before calling a CPS agency to report suspected child abuse or neglect, unless the emergency nature of the situation requires immediate action. Clinical supervisors can help determine whether the staff members are dealing with countertransference issues or inappropriate attachment. Staff members should be guided primarily by a trained understanding of the Federal requirements and the written procedures established by the treatment program. Other staff members can offer support, especially when the decision to report is difficult. (2)

Treatment organizations and agencies should provide orientation for all new staff members to inform them about reporting policies and procedures. It is recommended that these policies include provisions requiring staff members to notify their supervisor or appropriate program personnel whenever they make a report. (2)

It is the decision of the client and his lawyer, not the counselor, to determine whether communication or cooperation with a CPS agency will benefit the client. Therefore, it is essential that the counselor communicate with the client's attorney *before* taking it upon herself to communicate with a CPS agency, *except when there is a legal mandate to report.* (2) If a lawyer calls with questions about a client's treatment history or current treatment, the counselor must avoid giving any information (even that the client is indeed in treatment), unless the client has consented in writing to the counselor's communicating with the lawyer. (2)

1 Working With Child Abuse and Neglect Issues

Child abuse and neglect pose an increasingly recognized and serious threat to the nation's children. In the last 10 years the reported cases of abused and neglected children more than doubled, from 1.4 million in 1986 to more than 3 million in 1997; substance abuse was involved in more than 70 percent of the cases. A recent survey of State child welfare administrators found that parental substance abuse was a factor in at least 50 percent of substantiated cases of child abuse and neglect. Moreover, 80 percent reported that substance abuse and poverty were the two primary factors contributing to abuse and neglect (U.S. Department of Health and Human Services [DHHS], 1999).

Children whose parents abuse substances are almost three times more likely to be abused and four times more likely to be neglected than other children (National Center on Addiction and Substance Abuse at Columbia University [CASA], 1999). Substance abuse is a contributing factor to the abuse of at least one third of the children in the child welfare system (DHHS, 1999). It is estimated that each day five children die as a result of child abuse or neglect—up from three a day reported in 1994 (CASA, 1999; McCurdy and Daro, 1994). In reported cases, the most pervasive form of child maltreatment is neglect (60 percent), followed by physical abuse (25 percent), sexual abuse (13 percent), and emotional maltreatment (5 percent). More than 50 percent of the victims were 7 years old or younger; slightly more than half of victims were girls (Sedlak and Broadhurst, 1996).

Statistics will vary because of differences in criteria and methodology and because many cases of child maltreatment involve overlapping forms of abuse or neglect. (More details regarding the prevalence of child abuse and neglect are provided later in this chapter, along with specific definitions of what is meant by the terms "child abuse" and "neglect.") For the same reasons, it is difficult to determine if the incidence of child maltreatment is actually continuing to rise or not. However, researchers, counselors, and program administrators agree that the rise in substance abuse disorders as a factor in child abuse and neglect cases has severely complicated efforts by child welfare systems to protect children and rehabilitate families (CASA, 1999; DHHS, 1999).

Parents with substance abuse problems are less educated and less likely to be employed full time; they are much less likely than other parents to be married and much more likely to be involved in the welfare system (DHHS, 1999). However, these statistics may result from a population's reliance on public welfare systems; parents in higher socioeconomic classes can afford private systems where reporting is not mandated.

Many clients in substance abuse treatment have histories of child abuse or neglect that might affect their chances for recovery. There is accumulating research and clinical evidence that physical, sexual, and emotional abuse and neglect during childhood increase a person's risk of developing substance abuse disorders (DHHS, 1999). In addition, relapse and treatment complications may be more likely if issues related to maltreatment are not identified and treated (Brown, 1991; Rose, 1991; Young, 1995). The counselor might have more difficulty engaging clients with abuse histories, and these clients may have a variety of disabling comorbid conditions, such as posttraumatic stress disorder (PTSD) and dissociative disorders.

Given the presence of substance abuse in the majority of child abuse or neglect cases, alcohol and drug counselors may also have reason to suspect, or may discover, that clients are abusing or neglecting their own children. The children of substance-abusing parents will also face an increased risk of developing a substance abuse disorder themselves. A recent study confirms what has long been suspected, that children of alcoholics (whether or not they have been abused) have an altered brain chemistry that may make them more likely to become alcoholics themselves (Wand et al., 1998).

If the cycle of intergenerational substance abuse and child abuse and neglect is to be broken, counselors must address these issues. This is discussed in Chapter 5. Counselors will sometimes find it challenging to maintain the therapeutic alliance with clients that is central to successful treatment while meeting their legal obligations to report suspected or known maltreatment (see Chapter 6).

Substance Abuse and Child Abuse and Neglect

Treatment providers have observed that a large proportion of their clients report being physically, emotionally, or sexually abused as children. This clinical knowledge is increasingly supported by research findings. Most of this research has focused on one of two questions:

1. Are people with substance abuse disorders more likely to have been abused or neglected as children than are people without substance abuse disorders?
2. Are those who report a history of childhood abuse or neglect more likely than their peers to have a substance abuse disorder?

Specific answers to these questions depend to some extent on gender, and therefore the literature for men and women should be examined separately. Because most of the available information in this area focuses on childhood sexual and physical abuse, this TIP primarily addresses these two forms of maltreatment. As noted above, however, neglect is the most prevalent type of child maltreatment, and witnessing domestic violence is also a common (and potentially damaging) form of childhood trauma. (See TIP 25, *Substance Abuse Treatment and Domestic Violence* [CSAT, 1997b] for more information on how to deal with this significant problem.)

Rates Among Adolescent Girls and Women

A review of several studies found that women who abuse alcohol reported higher rates of childhood sexual and physical abuse than their peers without such disorders (Langeland and Hartgers, 1998). The likelihood of substance abuse disorders was directly related to the severity of childhood abuse as well. A more exhaustive literature review found that women with substance abuse disorders were nearly two times more likely than women in the general population to report childhood sexual abuse. These women were also more likely to have experienced physical abuse (Simpson and Miller, 1998).

Miller and her colleagues found that 70 percent of women in treatment for alcohol use disorders reported some form of childhood sexual abuse, while only 35 percent of the women in the general population did the same (Miller et al., 1993). Twelve percent of the women with alcohol use disorders did *not* suffer any form of sexual or physical abuse, compared with 41 percent of the control sample. The study concluded that parental alcoholism and child abuse were both independent risk factors for problematic drinking among adults, suggesting that childhood abuse itself contributes uniquely to the genesis of substance abuse disorders.

A 1995 literature review reveals a link between childhood sexual abuse and substance abuse (Polusny and Follette, 1995). In community samples, the authors found that the lifetime diagnosis rate of substance abuse disorders was 14 to 31 percent among women who had been sexually abused and 3 to 12 percent among women who had not been abused. In clinical samples, the rate of lifetime substance abuse diagnoses among sexual abuse survivors ranged from 21 to 57 percent, compared with a range of 2 to 27 percent for women without such histories. Another representative study of young adults found that 43.5 percent of the women who had been sexually abused as children met diagnostic criteria for an alcohol abuse disorder, while the criteria were met by only 8 percent of those who had not been sexually abused (Silverman et al., 1996).

The available research does indicate that women with substance abuse disorders are more likely than other women to report childhood abuse and women with childhood abuse histories are more likely than other women to have substance abuse disorders. Despite these findings, it is unclear to what extent the relationship between childhood abuse and the development of substance abuse is causal. Genetics, for example, might account for the association—child abuse might simply be incidental to the process in which the genetic propensity for drinking is passed from parent to child. Childhood stress from sources other than abuse and neglect might also contribute to substance abuse among adults (Malinosky-Rummell and Hansen, 1993). However, even when parental history of alcohol problems and measures of childhood stress are statistically controlled, childhood sexual and physical abuse still seem to contribute significantly to the alcohol-related problems of women (Bennett and Kemper, 1994; Miller et al., 1993).

Rates Among Adolescent Boys and Men

There are fewer studies of child abuse among boys and men with substance abuse disorders, and findings are less consistent than those generated for girls and women. One group of researchers believes that data are insufficient to determine (1) whether men with alcohol abuse disorders are more likely than their peers to have suffered childhood abuse, or (2) whether men with childhood abuse histories are more likely than other men to have alcohol abuse disorders (Langeland and Hartgers, 1998).

Simpson and Miller found 27 studies that addressed the issue of childhood abuse and neglect among men with substance abuse disorders (Simpson and Miller, in press). Only 10 of these studies found childhood sexual abuse rates higher than the national average of 16 percent (Finkelhor et al., 1990), and only six of these studies found rates above 10 percent. Most studies reveal that men with substance abuse disorders actually suffered less sexual abuse than their peers; however, these men did report unusually high rates of childhood physical abuse.

The few prospective studies of childhood abuse among men suggest that abuse does increase the risk of alcohol abuse (Simpson and Miller, 1998). Men who report childhood abuse also may be more likely to have a substance abuse disorder, but this conclusion is not certain. Societal expectations of self-reliance and fear of homosexual stigmatization may prevent these men from disclosing childhood sexual abuse (Briere et al., 1988). Current trends, however, suggest that men are becoming more willing to disclose histories of sexual abuse. Although the incidence of abuse has remained stable for women, far more men are reporting sexual abuse than have done so in the past (Simpson and Miller, 1998). Men with substance abuse disorders are also reporting more childhood physical abuse. Current study techniques simply may be more sensitive for sexual abuse among men, but further study is needed.

Most studies that have examined the rates of substance abuse among men with child abuse histories have found elevated rates of substance abuse disorders (Simpson and Miller, 1998). One important exception to this pattern is a study that examined the rates of arrest for alcohol- and drug-related offenses among young adults with and without documented histories of childhood abuse or neglect (Ireland and Widom, 1994). This study found no relationship between a history of childhood abuse and neglect and substance abuse problems among men. It should be mentioned, however, that Ireland and Widom did not assess whether the study participants experienced child abuse or neglect that was not officially reported. Some of those who were classified as not having been abused or neglected may have experienced such maltreatment, and the results of this study are therefore difficult to interpret.

Most of the available literature indicates that men with childhood abuse histories are more likely to have substance abuse disorders than men without childhood abuse histories (Simpson and Miller, 1998). The rates of childhood physical abuse appear to be higher among men with substance abuse disorders than among men from the general population. However, men with substance abuse disorders do not report more childhood sexual abuse than other men. Holmes and his colleagues uncovered several factors that contribute to the reluctance of men to report sexual abuse (Holmes et al., 1997). The shame, homosexual stigmatization, and perceptions of weakness associated with disclosure are perceived by many men to be more burdensome than the secret of abuse. Also, men are prone to minimize the negative effects that childhood sexual abuse may have, though men who were sexually abused as children are at greater risk than their nonabused peers for later psychological and emotional difficulties. Holmes and colleagues found that when men disclose a history of child abuse to their mental health counselors, its importance is often dismissed. The researchers concluded that the childhood sexual abuse of males is viewed with far less gravity then the childhood abuse of girls and women (Holmes and Slap, 1998; Holmes et al., 1997).

Implications for Treatment of Clients With Child Abuse Histories

Mental Health Issues

Adults with histories of child abuse and neglect may differ from other clients in a number of ways. Although the research base is still limited, clients with childhood abuse histories have been found to have more severe substance abuse disorders, to have started using at younger ages, and to use substances for reasons that differ from other clients. They are also more likely to have attempted suicide, to have PTSD, and to have personality or relationship problems that make them hesitant to accept help (Felitti et al., 1998), which also makes them more vulnerable to relapse.

Clients who have been sexually or physically abused as children often attribute at least part of their substance abuse to their childhood victimization. Hayek found that more than two thirds of women with incest histories believed that the abuse contributed to their alcoholism (Hayek, 1980). Another study revealed that 25 percent of incest victims in alcohol treatment programs believed their drinking problems were caused by their incest experiences (Janikowski and Glover, 1994). Individuals with alcohol abuse disorders and histories of sexual or physical abuse believe that their trauma was a considerable factor in causing their drinking problems and that it was a moderate factor in precipitating their most recent relapses (Brown et al., 1993).

Researchers who have focused on women and girls have found that those with histories of childhood abuse are likely to have developed their substance abuse problems at a younger age (Edwall and Hoffman, 1987; Jarvis et al., 1998; Paone et al., 1992) and that adolescent girls in this group are more likely than their nonabused peers to use cocaine, amphetamines, sedatives, and tranquilizers (Harrison et al., 1989a). Women in substance abuse treatment programs who were sexually abused as children use alcohol to facilitate sexual encounters more often than do other women (Hayek, 1980; Hurley, 1990; Lammers et al., 1995). They are also more likely than their nonabused peers to use substances to alleviate pain (Jarvis et al., 1998), escape family turmoil, and calm tremors (Harrison et al., 1989a). Women might also use substances to escape memories of sexual abuse (Miller and Downs, 1995; Young, 1995).

Alcohol abuse disorders are more severe among men who were sexually abused as children (Simpson, in press; Simpson et al., 1994) and may include overdoses and substance-related seizures (Krinsley et al., 1994). They are also more likely to have gone on "suicidal drinking" binges (Kroll et al., 1985). Suicide is a major problem among clients who were abused as children. These clients are more likely than their nonabused peers to attempt suicide, according to most studies (Harrison et al., 1989b; Jarvis et al., 1998; Krinsley et al., 1994; Wallen and Berman, 1992; Windle et al., 1995). Moreover, the first attempt increases the risk of others (Linehan, 1993a), so that these clients are more likely to attempt suicide again. Research is inconclusive about whether clients with childhood abuse histories are more depressed than their peers. Some findings suggest they are (Benward and Densen-Gerber, 1975; Boyd et al., 1997; Deykin et al., 1992), although others suggest they are not (Krinsley et al., 1992; Neisen and Sandall, 1990; Windle et al., 1995).

PTSD is relatively common among people who were abused physically or sexually as children (Polusny and Follette, 1995; Rowan and Foy, 1993). Among people with substance abuse problems, those with histories of childhood abuse are more likely to meet diagnostic criteria for PTSD (Brady et al., 1994; Hien and Levin, 1994; Krinsley et al., 1992), and PTSD is associated with less successful treatment outcomes (Brady et al., 1994; Brown et al., 1995; Stewart, 1996).

People abused as children are also prone to dissociative disorders (Polusny and Follette, 1995), but it is unclear whether people who have substance abuse disorders and childhood abuse histories engage in more dissociative behaviors than those without childhood abuse histories.

Research on male clients in substance abuse treatment has found that those with childhood abuse histories do not report more dissociation than their nonabused peers (Dunn et al., 1993, 1995), but research on female clients in substance abuse treatment suggests that those who were abused as children use a wider variety of dissociative behaviors than other women in treatment (Jarvis et al., 1998). Ostendorf, however, found that female incest victims with alcohol problems scored lower on an index of dissociation than those without alcohol problems (Ostendorf, 1995). Alcohol, the author suggested, may serve the same functions for some as dissociation does for others. More research is needed in this area to clarify the importance of dissociative disorders among clients with childhood abuse histories.

Clients abused as children also seem to be at higher risk than their peers for other mental health and social problems. These include antisocial personality disorder (Windle et al., 1995), legal problems (Brabant et al., 1997; Krinsley et al., 1994; Kroll et al., 1985; Paone et al., 1992), and paranoia (Jarvis et al., 1998; Krinsley et al., 1992; Kroll et al., 1985). Women with substance abuse disorders and childhood abuse histories are more likely than other women in treatment to report sexual problems and abnormal sexual behaviors (Edwall et al., 1989; Hayek, 1980; Jarvis et al., 1998; Swift et al., 1996; Wallen and Berman, 1992). Clients who were abused as children are also more likely than others in treatment to be assaulted as adults, both physically (Edwall and Hoffman, 1987; Edwall et al., 1989; Haver, 1987; Lammers et al., 1995) and sexually (Wallen and Berman, 1992), and they are more likely to develop PTSD following the attack (Brady et al., 1994).

Risk for Relapse

Relapse is common during the treatment of substance abuse, and few clients achieve permanent abstinence on their first attempt. Although clinicians have applied a variety of promising pharmacotherapeutic and psychosocial strategies to prevent relapse (Carroll, 1997), relapse rates remain high (Miller et al., 1995a).

Many in the field believe that recovery from substance abuse is even more difficult for people who were abused as children (Brown, 1991; Rose, 1991; Young, 1995). There is fairly strong evidence that men who were abused as children enter treatment more often than other men (Krinsley et al., 1994; Simpson et al., 1994). This suggests that these men may be at greater risk for posttreatment relapse. Studies that combined males and females have also found poorer treatment compliance and outcomes for those who were victimized as children (Carran et al., 1996; Glover et al., 1996; Palmer et al., 1995). Gutierres and colleagues, however, did not find a connection between childhood abuse and treatment completion among males and females (Gutierres et al., 1994).

Childhood abuse does not seem to affect treatment outcomes among women. Women who were sexually assaulted as children do not relapse any more frequently than other women in the year following treatment (Stephenson, 1990). Childhood sexual abuse is not associated with either the likelihood of a woman attending her first referral appointment following detoxification (Hien and Scheier, 1996) or the likelihood that she will complete subsequent treatment (Wallen and Berman, 1992). Childhood abuse is also unrelated to the number of times a woman enters treatment (Brabant et al., 1997; Simpson et al., 1994).

Incest victims, moreover, do not report having tried more treatment modalities or having had more relapses than other women (Jarvis et al., 1998; Kovach, 1983). However, Haver reported poorer treatment outcomes among women who were physically abused by their mothers (Haver, 1987). In a study of aftercare compliance following childbirth, 67 percent of noncompliant women reported some form of childhood abuse while only 25 percent of compliant mothers did the same (Killeen et al., 1995).

Implications for Treatment Providers

The Consensus Panel recommends that alcohol and drug counselors be aware of childhood abuse and the issues involved in its treatment for the following five reasons:

1. People who were abused as children are more likely than others to attempt and reattempt suicide, as noted earlier. Alcohol and drug counselors, therefore, must watch for signs of suicidal ideation. Counselors should work to help clients ease the emotional burdens of past abuse in order to diminish the likelihood of suicide.
2. Counselors may need to address childhood sexual and physical abuse in order to reduce clients' risk of abusing their own children. Most abuse survivors do not abuse their own children (Kaufman and Zigler, 1987), although people with substance abuse disorders are at greater risk of doing so. As reported above, substance abuse contributes to almost three fourths of the incidences of child abuse and neglect (CASA, 1999; Famularo et al., 1992; Finkelhor et al., 1983; McCurdy and Daro, 1994). At least 675,000 children are abused or neglected each year by parents or caretakers with substance abuse disorders, and more than 8 million children (11 percent) in the United States are being raised by substance-abusing parents (DHHS, 1999). Although it is not known how many of these parents are struggling with their own abuse histories, counselors should be able to address their clients' abuse issues in order to break the cycle of addiction and violence.
3. Clients often suspect that childhood abuse contributed to their substance abuse disorders and relapses. Although they are not likely to identify precise clinical syndromes, clients may seek help in overcoming the emotional pain of childhood abuse. Counselors should be able to help these clients so that they do not turn to substances for relief.
4. By addressing child abuse issues, the risk of relapse among clients who were abused as children might actually drop below that of their nonabused peers. Preliminary evidence suggests that people with childhood abuse histories use substances as a means of "chemical dissociation." Once trauma issues are resolved, substance use may clear substantially (Roesler and Dafler, 1993).
5. People who were severely sexually or physically abused as children often develop PTSD (Rowan et al., 1994; Wolfe et al., 1994), and this disorder increases their risk of relapse because it engenders intrusive memories and attempts to avoid those memories through self-medication (Kuyken and Brewin, 1994). Therefore, clients suffering from abuse-related PTSD are likely to have endured the most severe forms of abuse. Counselors should be aware of this and know how to help such clients.

Cultural Considerations

Few researchers have studied the influence of ethnic and racial factors on childhood abuse and substance abuse disorders, but specific populations have been the object of several recent studies. For example, Carol Boyd and her colleagues researched crack cocaine addiction among African-American women (Boyd et al., 1997). Boyd's findings for this group are consistent with the larger body of research described earlier. The limited evidence in community-based samples suggests that there are not significant ethnic or racial differences in the base rate of childhood sexual abuse between

African-Americans and Whites and between Hispanics and Whites (Arroyo et al., 1997).

Another study reveals similar rates of emotional, physical, and sexual abuse among Native Americans, Mexican-Americans, and European-Americans in treatment for substance abuse (Gutierres and Todd, 1997). However, Native American women reported substantially more physical abuse than other women, and European-American men reported more sexual abuse than other men. This research, along with Boyd's work, points to the possibility of problems specific to groups, as well as the likelihood of differences in group reporting.

Treatment providers must be sensitive to the ways in which cultural factors interact with a client's child abuse or neglect history. In a review on the relationship between racism and mental health, racism was found to be a major contributor to psychopathology among ethnic minorities (Carter, 1994; Landrine and Klonoff, 1996; Thompson, 1996). Sensitivity to such cultural phenomena helps facilitate effective interventions for ethnic minorities who have experienced childhood abuse (Manson, 1997). The Consensus Panel urges alcohol and drug counselors to be aware of how clients' backgrounds may affect treatment.

Some of the challenges faced by culturally diverse populations seeking treatment are disparities in access and availability of services, and language and literacy differences. It is also important for counselors to be aware that sensitivity to cultural issues includes avoiding a double standard—being overly tolerant or flexible because of uncertainty about unfamiliar social norms. Cultural differences should not be allowed to excuse abusive or neglectful behavior by parents.

Incidence of Child Abuse And Neglect

Child protective services (CPS) agencies received reports of over 3 million suspected cases of child abuse and neglect in 1996. CPS staff investigated 75 percent of these reports and substantiated more than 970,000 cases of child maltreatment in that year alone (DHHS, 1999; Sedlak and Broadhurst, 1996). The reported incidence of child abuse and neglect climbed from 41 children per 1,000 in 1990 to 44 children per 1,000 in 1996. Even more disturbing, researchers agree that most incidents—as many as 70 percent—of child abuse and neglect still go unreported (Briere, 1992a; DHHS, 1999).

It is estimated that 42 of every 1,000 children in the United States (under age 18) have been either abused or neglected. The number of sexually abused girls is three times the number of boys, but boys are more likely than girls to be seriously injured by abuse (Holmes and Slap, 1998). Boys are also more likely to be emotionally neglected. As noted above, there seem to be no significant differences among racial and ethnic groups in the incidence of maltreatment or maltreatment-related injuries (Sedlak and Broadhurst, 1996).

Child maltreatment may not necessarily be on the rise; society may be more informed about reporting procedures, and victims may be more educated on resources, safety in disclosure, and ability to seek help in comparison to the past. Some researchers suspect that the tremendous rise in child abuse rates may be largely due to heightened awareness of the issue by society in general (Van Dam et al., 1985). Some of the increase in reported cases may also stem from greater sensitivity among researchers to the subtle cues of abuse and neglect. However, the rate of serious injuries due to child abuse has risen dramatically (Sedlak and Broadhurst, 1996), and (as noted above) the incidence of abuse and neglect might be underestimated as a result of underreporting. Indeed, in one review of children's death certificates, 85 percent of abuse- and neglect-related deaths had been attributed to other causes (McClain et al., 1993).

Incidence of Child Abuse And Neglect Histories Among Adults

Given the high incidence of documented abuse and neglect among children, it is reasonable to assume that a sizable proportion of adults experienced similar childhood trauma. However, the true incidence of childhood abuse and neglect among adults is unknown. Research definitions have not been consistent, and this makes estimations difficult (Wyatt and Peters, 1986a). Inclusive definitions yield substantially higher estimates of abuse and neglect, while narrow definitions yield lower ones. Variations in research methods (e.g., questionnaires versus interviews) and populations studied also affect estimates (Wyatt and Peters, 1986b).

A large national study of randomly identified adults in the United States estimates that 27 percent of women and 16 percent of men were sexually abused as children (Finkelhor et al., 1990). Additional estimates of childhood sexual abuse among women range from approximately 7 percent (Burnam et al., 1988) to 54 percent (Russell, 1983). The actual incidence of childhood sexual abuse is unknown (Trickett and Putnam, 1993). The true incidence among adults of other forms of childhood abuse and neglect is also unclear. Physical maltreatment has been studied less than childhood sexual abuse, and inconsistent methods and definitions have made the results uncertain. The incidence of emotional abuse and neglect among adults has not been significantly studied.

Long-Term Consequences of Child Abuse and Neglect

Although a causal relationship has been difficult to establish, investigators report that childhood abuse and neglect are associated with later problems. Sexual abuse, for instance, has been linked to depression, anxiety, and sexual dysfunction as well as eating, personality, dissociative, and substance abuse disorders (Beitchman et al., 1992; Browne and Finkelhor, 1986; Cahill et al., 1991; Polusny and Follette, 1995). People sexually abused as children are more likely than others to have social difficulties, and their risk of physical and sexual assault is greater (Polusny and Follette, 1995). One review of the physical abuse literature found that physically abused boys are more likely to become substance abusers, though the reviewers did not include any studies of the risk of substance abuse among physically abused girls (Malinosky-Rummell and Hansen, 1993). Low self-esteem (Briere and Runtz, 1990b) and depression (Braver et al., 1992) are relatively common among college students who were emotionally abused. In fact, they are more common among those who were emotionally abused than they are among those who were physically abused (Gross and Keller, 1992; Ney et al., 1993).

Defining Abuse and Neglect

Alcohol and drug counselors must understand the definitions of abuse and neglect in order to adequately screen and assess clients who were exposed to them as children. Counselors must also know the definitions because they, like all clinicians, are required by law to report suspected or known child abuse (see Chapter 6).

Clinicians who understand the definitions of child abuse and neglect can also help clients who might not recognize that they were abused or neglected as children. According to researchers, some adults tend to deny, minimize, or forget experiences of abuse (Brown et al., 1999; Della Femina et al., 1990; Kufeldt and Nimmo, 1987). For example, Williams interviewed a sample of women in the early 1990s who had documented histories of sexual abuse occurring between 1973 and 1975 (Williams, 1994). Forty percent of the women failed to report the documented abuse during their assessments. Many of the women in this subgroup, however, did report other instances of childhood sexual abuse, leading the author to suggest that these women may in fact have traumatically forgotten the documented abuse.

General Definition

Both Federal and State legislation define child abuse and neglect. The Federal legislation provides a foundation for States by identifying a minimum set of acts or behaviors that constitute maltreatment. The Child Abuse Prevention and Treatment Act (42 U.S.C., §5106g), enacted in 1974 and reauthorized in 1996, defines child abuse and neglect as, at minimum, any recent act or failure to act that results in "imminent risk of serious harm, death, serious physical or emotional harm, sexual abuse or exploitation" (Courtney, 1998) to a child under the age of 18, or, except in the case of sexual abuse, under the age specified by the child protection law of the State, by a parent or caretaker (including any employee of a residential facility or any staff person providing out-of-home care) who is responsible for the child's welfare. The act defines sexual abuse as

- Employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or to assist any other person to engage in, any sexually explicit conduct or any simulation of such conduct for the purpose of producing any visual depiction of such conduct
- Rape, prostitution, and in cases of caretaker or interfamilial relationships, statutory rape, molestation, or other form of sexual exploitation of children
- Incest with children (although legal definitions may vary from State to State, incest can be broadly defined as the imposition of sexually inappropriate acts, or acts with sexual overtones, by one or more persons who derive authority through ongoing emotional bonding with that child—or any use of a minor child to meet the sexual or emotional needs of such persons)

Each State is responsible for providing definitions of child abuse and neglect within this civil and criminal context. Laws vary widely from State to State, and treatment providers must be familiar with the definitions outlined in their own State's laws. In particular, they must understand *reporting laws*, which describe the circumstances and conditions under which they are obligated to report known or suspected abuse or neglect. These laws also list the conditions under which counselors are allowed to report known or suspected cases described to them by a third party. Counselors should also be familiar with juvenile/family court acts that dictate when a court is allowed to take custody of a child alleged to have been abused or neglected. The definitions in these acts are often the same as those in the reporting law. Finally, treatment providers should know the criminal law in their State that defines criminally punishable forms of abuse and neglect—such as sexual abuse, severe physical abuse, and child endangerment—and the reporting requirements (see Chapter 6 for further information).

Types of Abuse and Neglect

There are four major types of child maltreatment: neglect, physical abuse, sexual abuse, and emotional or psychological abuse.

Neglect

Neglect is the failure to provide for a child's basic needs. Neglect can be physical, educational, medical, or emotional. *Physical neglect* is the most common type of neglect, and it includes the failure to meet a child's basic needs for food, shelter, and clothing that is not due to a lack of financial resources. Physical neglect also encompasses inadequate supervision and abandonment of a child, expulsion from home, and rejection of a runaway who wishes to return home. *Educational neglect* is the second most frequent type of neglect and includes failing to enroll a child in school, allowing chronic truancy, and not attending to a child's special educational needs. *Medical neglect* involves the refusal of, noncompliance with, or avoidable delay in seeking health care. *Emotional neglect*, which, like emotional abuse, is difficult to document, includes marked inattention to a child's needs for affection, refusal of or failure to provide needed psychological care, or chronic or extreme spousal abuse in the child's presence.

The assessment of child neglect requires consideration of cultural values and standards of care, as well as recognition of the role of poverty in failure to provide the necessities of life. In substance-abusing families, neglect is a much more common reason than physical abuse for a parent to be reported to CPS agencies. In one study of children in foster care who had substance-abusing parents, neglect or abandonment accounted for 70 percent of placements, whereas physical abuse accounted for only 15 percent. For children placed in foster care from families in which substance abuse was not a factor, neglect or abandonment accounted for 37 percent of the cases and physical abuse accounted for 33 percent (Walker et al., 1994).

Physical abuse

Physical abuse can range from minor bruising to killing a child and may involve a single act or repeated occurrences. It is characterized by physical injury inflicted by punching, beating, kicking, biting, burning, or other actions. Such injuries are not accidental, although caretakers may not believe that they intended to harm the child. Physical abuse includes punishment that is not appropriate to a child's age, size, or physical, mental, or emotional condition. Normal disciplinary measures do not require medical treatment, nor do they leave physical marks, such as welts and bruises. Any punishment that involves hitting with a closed fist or with an instrument, as well as kicking, burning, or throwing the child is considered abuse regardless of the severity of the injury.

Sexual abuse

Sexual abuse or incest involves a range of behaviors—including all forms of oral-genital, genital, or anal contact with the child (such as fondling a child's genitals), or nontouching abuse (e.g., exhibitionism, voyeurism), as well as sexual penetration (e.g., intercourse, rape, sodomy), and commercial exploitation of the child via prostitution or the production of pornography. It involves not only acts committed by the perpetrator but inappropriate actions the child is forced or encouraged to perform on the adult. Child sexual abuse means engaging a child in sexual activities that the child cannot comprehend, for which the child is developmentally unprepared, and for which he cannot give informed consent.

Most State laws distinguish between sexual abuse and sexual assault: An act of abuse is perpetrated by a person who has some responsibility for the child's care, whereas an assault is committed by someone other than a caregiver. However, researchers and survivors of childhood abuse perceive that caregivers or relatives who engage a child in sexual activity by use of force, life threats, and beatings are by definition committing sexual *assault*. For more information on consequences of sexual abuse and assault, see Funk, 1980; Gomes-Schwartz et al., 1985; Paradise et al., 1994; and Sullivan et al., 1979.

Emotional or psychological abuse

Emotional or psychological abuse includes acts of commission or omission by parents or caregivers that have caused, or could cause, serious behavioral, cognitive, emotional, or mental disorders. Examples include the verbal or emotional assault of a child as well as the child's extreme confinement by ropes or other means. Emotional abuse often coexists with other forms of abuse, and it is the most difficult to identify. Many of its potential consequences, such as learning and speech problems and delays in physical development, can also occur in children who are not being emotionally abused. In addition, the effects of such abuse may not be evident until later in life. In some States, a CPS agency can intervene in cases of emotional or psychological abuse without evidence of harm to the child's behavior or condition. Only proof of an extreme form of psychological punishment, such as confining the child to a closet, is required. CPS agencies in these States will not, however, intervene in cases of excessive rejection, blame, or belittlement without proof of harm.

Factors Affecting Research And Screening

Variations in the definitions of child abuse and neglect have made it difficult to assess the extent of the problem and its prevalence in the histories of adults. Although definitions have not yet been standardized (Briere, 1996; Whipple and Richey, 1997), researchers recognize consistency in definitions as an important goal. At present, researchers debate whether to define child abuse and neglect by their impact on the child's development (Garbarino, 1977; Garbarino et al., 1986) or by community standards for appropriate behavior toward children. These distinctions have been central in trying to define emotional abuse, but they have also helped frame discussions about other forms of abuse and neglect. However, in an effort to discourage overly zealous interventions, policymakers tend to advocate narrow definitions of emotional abuse that require proof that the child was harmed (see McGee and Wolfe, 1991, for a discussion of the issues). Some researchers, however, argue for definitions of emotional abuse that are independent of the apparent effects of the abuse (Barnett et al., 1991; Shaver et al., 1991). Emotional abuse and neglect are often ranked on a continuum, and participants are not typically categorized by the mere occurrence or absence of maltreatment. This continuum approach is becoming more common in the study of child abuse (Bernstein et al., 1994).

Child sexual abuse is often defined broadly by researchers as any unwanted sexual experience occurring before the age of 18, including genital exposure and verbal propositions (Wyatt and Peters, 1986b). More restricted definitions typically specify that the experience must have involved physical contact with someone at least 5 years older than the victim if the victim is under a certain age, usually 15 through 18 years old (Krinsley et al., 1992; Rohsenow et al., 1988). The broader conceptualization of sexual abuse yields substantially higher rates of reporting than do more narrow definitions. Acts of physical violence aimed by a parent or caretaker toward a child are considered by most to be abuse, though many studies also specify that the child must have been physically injured (Straus and Gelles, 1990; Whipple and Richey, 1997).

Simply asking clients if they were abused or neglected as children is no longer considered an adequate evaluation of maltreatment (Briere, 1992b; Miller and Downs, 1995; Wyatt and Peters, 1986b). Instead, clients are provided clear behavioral descriptions of experiences to which participants respond "yes" or "no." For example, MacMillan and colleagues used the following questions to assess physical abuse:

"During childhood, did an adult often or sometimes push, grab, or shove you? Throw something at you? Hit you with something? Did an adult often, sometimes, or never kick, bite, or punch you? Choke, burn, or scald you? Physically attack you in any other way?" (MacMillan et al., 1997). The number of and manner in which such questions are asked influence the way they are answered. Also, spurious links between child abuse and other symptoms can sometimes be made. Patients with psychiatric disorders, for example, frequently search their past lives for some explanation of their distress (Pope and Hudson, 1992).

Underreporting of sexual abuse appears to be much more likely than overreporting. A therapeutic alliance may have to exist before a patient will disclose an incest history (Pribor and Dinwiddie, 1992). It may be necessary to pose questions at an intake history and then again later in the therapeutic process. For the same reasons of client reticence, Miller and Downs recommend a self-report questionnaire combined with an interview (Miller and Downs, 1995). Each method has been shown to identify cases of abuse missed by the other. See Chapter 2 for more on this issue.

One of the critical new areas of research on people with substance abuse disorders is the study of "resilience factors" that permit some sexually abused individuals to avoid addiction, while others become addicted. Research demonstrates, for example, that victimized women who become alcoholics experienced prolonged, severe sexual abuse in isolation (Beckman and Ackerman, 1995). The courts' tendency to intervene minimally can perpetuate isolation and make the development of resilient behavior less likely. Another study notes a variety of specific factors that affect resilience against addiction in individuals sexually abused in childhood, including level of self-esteem, quality of adolescent peer group, and extent to which PTSD symptoms are experienced (Miller and Downs, 1995). A client's ability to dissociate may actually promote resilience against addiction. It will be very difficult to do any type of resilience studies if "sexual abuse" is not defined as such unless there has been some measurable negative outcome for the victim.

Personal Meanings of Abuse

Counselors must recognize when it is appropriate or necessary to report incidents of clients' maltreatment of their children to government agencies, and for this they must know legal definitions of abuse and neglect. However, a broader approach, especially one that considers the meaning of the experience to the client, may be more useful in treatment. Finkelhor, for example, notes how sexual abuse may alter a child's perception of the world (Finkelhor, 1987). It is this altered perception, he argues, that leads to the devastating consequences of abuse. The sexually abused child might well feel betrayed and, as a result, no longer trust others (Springer, 1997). Stigmatization and shame may compromise the child's self-esteem, as well. People who were traumatized might even question their very right to exist (Greening, 1997).

Clinicians must, therefore, understand how clients interpret their experiences. Not all abuse meets the legal or commonly held criteria for abuse; nor will all clients perceive as abusive those experiences which fit the legal definition. For example, a client might report being spanked every day as a small child and might feel that he deserved the spankings because he disobeyed his mother. He might also explain that his mother loved him and that the spankings occurred within a context of caring. Such a client would deny that he had been abused as a child and would not be well served by therapists who insisted otherwise. In contrast, another client may have accepted chronic belittling and criticism while growing up and may not understand its relationship to career failures and repeated relapses.

The Difficulty of Distinguishing Poverty From Neglect

Almost every theoretical model of child abuse and neglect recognizes the contribution of stress to poor outcomes, and poverty is a major source of family stress. Substandard and overcrowded housing in unsafe neighborhoods strains families, as do unemployment and discrimination. In some cases, impoverished families should not be subjected to accusations of intentional child neglect (Besharov and Laumann, 1997). CPS agencies can help counselors understand which cases truly merit investigation and which should be referred to other agencies. Counselors can contact CPS agencies and discuss confusing cases without identifying individuals and families. Counselors can also refer clients to various agencies to help them secure child care, food stamps, and free family health care as needed. (See "Role of Child Protective Service Agencies" in Chapter 5 for more information on working with the child welfare system.) Child neglect and the conditions of poverty often overlap. Even when there is no intent, physical and emotional injury can still occur. Disenfranchisement may lead to deviance, such as criminal activity, that may have an unintended impact on children, as when a parent is arrested or incarcerated. It is the responsibility of the counselor to report instances of reasonable suspicion of abuse or neglect; however, counselors should use caution when distinguishing cases of class and cultural differences from child abuse and neglect. A comprehensive assessment should be conducted before any conclusions are reached. Many CPS agencies provide training for counselors on mandated reporting requirements, and some CPS agencies have the resources for assisting families. See Chapter 6 for more information on requirements and guidelines for reporting.

2 Screening and Assessing Adults For Childhood Abuse And Neglect

Substance abuse is a chronic and relapsing condition. It is often associated with problems in physical, psychological, emotional, spiritual, and social functioning (Brown, 1998; Landry, 1994). These problems are not likely to be the result of one specific cause but rather the result of an accumulation of factors that clients have faced in their lives (Luthar and Walsh, 1995). Risk factors associated with substance abuse disorders include histories of childhood abuse and neglect (Carlson, 1997). In fact, a recent study found that adults with histories of child abuse have an increased likelihood of heart disease, cancer, and chronic lung disease, as well as greater risk for alcoholism, drug abuse, depression, and attempted suicide (Felitti et al., 1998). These findings emphasize the importance of comprehensive screening and assessment for individuals with substance abuse disorders and client access to adequate health care.

Although childhood abuse and neglect disproportionately affect adult substance abusers and their families, clients' substance abuse disorders are not often examined within the context of past abuse or neglect experiences. The reasons for not considering or eliciting this kind of historical information vary. Treatment providers may not have comprehensive screening and assessment measures available. Often, counselors simply fail to ask, or the intake organization does not instruct them to ask, about childhood abuse. Yet in some instances disclosure rates have risen dramatically when substance abuse treatment clients were asked directly about their experience of child abuse.

Clients may be unable to address traumatic childhood events because of memory problems that, in the past, have helped them cope with the trauma (Brown et al., 1999). Clients' family members may not be available or appropriate as family historians, and it is not the counselor's role to independently investigate family histories. Sometimes the immediacy of other problems causes assessments of child abuse and neglect to be delayed. Yet without proper screening and assessment, treatment providers may wrongly attribute symptoms of childhood trauma-related disorders to consequences of current substance abuse. Mental health issues often precede, rather than follow from, substance dependence. Therefore, comprehensive screening for root causes of clients' presenting symptoms may greatly increase the effectiveness of treatment.

Challenges to Accurate Screening and Assessment

Counselors face great challenges when screening for and assessing childhood abuse or neglect. Few adults are comfortable with a history of violation and neglect. Many abuse survivors are ashamed of having been victims of childhood physical, emotional, or sexual abuse and may feel that the abuse was self-induced. Screening and assessment, therefore, should be designed to reduce the threat of humiliation and blame and should be done in a safe, nonthreatening environment. Although family members can be an important part of a comprehensive assessment (with the client's consent), treatment providers should be aware of what impact their involvement may have on the client's safety (or the safety of the client's children) and which family members the client considers nonthreatening.

The following sections illustrate the challenges that treatment staff should anticipate and prepare for when screening for a history of childhood abuse or neglect and when assessing its impact on clients with substance abuse disorders.

Underreporting Trauma History or Symptoms

When screening for and assessing a history of childhood trauma, the counselor should ask clients to recall and indirectly reexperience abuse-related events (Briere, 1997). This process can trigger defense mechanisms—such as denial, minimization, repression, amnesia, and dissociation (Bernstein et al., 1994; Briere, 1992a; Cornell and Olio, 1991)—that diminish the distress associated with these events and memories (Fink et al., 1995). These mechanisms may cause a client to withhold or ignore information that is important for the assessment. Adult survivors of childhood trauma commonly suppress memories of certain traumatic events or minimize, either consciously or unconsciously, their symptoms (Brown et al., 1999; Whitfield, 1997). Frequently, such defense mechanisms relate to the shame and stigma of the events. Clients may fear retribution from perpetrators or family members or loss of contact with people on whom they are emotionally dependent. Minimizing has often served to protect family members from having to deal with the criminal justice system (including the possible arrest of the perpetrator). Also, clients may fear that treatment staff will assume that they are abusive to their own children and report them to the police or child protective services (CPS) agencies. Still others may have never perceived their experiences as abusive or harmful but rather as normal and deserved.

Certain sociocultural factors may encourage denial and minimization. For example, there is a social imperative among males to be strong and silent and unaffected by abuse. Physical abuse is difficult to evaluate because most males see their abuse as normal punishment for their behaviors (Langeland and Hartgers, 1998). Men may self-report child abuse and neglect less than women because their occurrence implies weakness and an inability to protect themselves (Evans and Sullivan, 1995; Holmes et al., 1997). Recent studies have concluded that sexual abuse of boys is underreported and undertreated (Holmes and Slap, 1998).

Issues of confidentiality, mandated reporting, and trust may influence responses to interviews and questionnaires by making some clients less inclined to reveal personal histories of abuse or neglect. Reporting requirements may vary from State to State (see Chapter 6 for more information on reporting child abuse and neglect). Maryland law, for example, requires that treatment providers report incidents of childhood abuse disclosed by adults in substance abuse treatment programs.

Repressed Memories

An important limitation of most of the research on childhood abuse is that it relies on retrospective recall of personal events that usually are not independently corroborated. This is a standard problem in many areas of research, but particular concerns have been raised about the retrospective recall of childhood sexual abuse. The primary concerns have revolved around the "false memory syndrome" and child sexual abuse that has been forgotten and later remembered in the context of counseling (Loftus, 1996). Laboratory research on memory indicates that people may be led to remember events that did not actually happen to them (Loftus, 1993). These findings have raised the concern that suggestible clients may be led by therapists to believe that they were sexually abused as children when they were not. Other research indicates, however, that people can only be led to believe that nontraumatic events happened to them and that they are much more impervious to suggestions that false traumatic events occurred (Bowman, 1996). See Farrants, 1998, for a review of the research on this subject.

Overreporting Trauma History or Symptoms

Recently, research has suggested that some individuals may overreport or misrepresent abuse histories or abuse-related symptomatology, although this does not normally happen (Briere, 1997). In such cases, the client's conscious or unconscious should be viewed as having significant pathology that may contaminate the screening and assessment processes. For example, some clients may report inaccurate abuse histories or symptoms so that they may receive treatment rather than be incarcerated, may receive inpatient instead of outpatient treatment, or may qualify for disability-related entitlements, such as Supplemental Security Income (LaCoursiere, 1993). Others may overreport their history of trauma or current trauma-related symptoms in an effort, consciously or unconsciously, to deny or minimize their substance abuse disorder. Although overreporting is probably a less frequent phenomenon than underreporting, staff should be aware of the possibility that clients may receive secondary gains from overreporting symptoms or the severity of past abuse. Just as many clients with substance abuse disorders tell "war stories," some, with a great deal of experience in treatment settings, have become experts at giving psychiatric labels to all their problems.

Coexisting Psychiatric Disorders

A number of studies have found that childhood maltreatment and trauma are significant risk factors for later psychiatric problems (Beitchman et al., 1992; Neumann et al., 1996; Polusny and Follette, 1995; Trickett and McBride-Chang, 1995). Indeed, individuals with a history of childhood trauma—such as being sexually abused, being physically assaulted, or repeatedly witnessing violence—often develop psychopathology during adulthood (Beitchman et al., 1992; Bryer et al., 1987; Malinosky-Rummell and Hansen, 1993; Pollock et al., 1990; Roesler and Dafler, 1993). Thus, many adults receiving treatment for substance abuse who have a history of childhood abuse and neglect will have a coexisting psychiatric disorder (see Figure 2-1). As mentioned in Chapter 1, abuse and neglect during childhood are particularly associated with major depression, suicidal thoughts, posttraumatic stress disorder (PTSD), and dissociative symptoms (Briere and Runtz, 1990a; Craine et al., 1988; Felitti et al., 1998; Rowan and Foy, 1993; Rowan et al., 1994). In treatment programs for veterans, where PTSD symptoms are often assumed to be occupation related, a history of childhood abuse can be particularly difficult to identify. Childhood abuse also has been associated with borderline personality disorders (Herman et al., 1989), as

Figure 2-1

Symptoms and Syndromes Associated With Childhood Abuse and Neglect

Most Common Responses

- Helplessness
- Low self-esteem
- Guilt
- Shame
- Anxiety
- Depression
- Anger
- Suicidal behavior
- Posttraumatic stress disorders
- Posttraumatic stress symptoms
- Substance abuse disorders
- Difficulty in close or intimate relationships

Less Common Responses

- Dissociation symptoms
- Dissociative (traumatic) amnesia
- Dissociative identity disorder
- Borderline personality disorder
- Antisocial personality disorder
- Somatization and other medical problems
- Compulsive and indiscriminate sexual activity
- Bingeing or chronic overeating
- Self-mutilation or other self-harm

Source: Adapted from Briere, 1997 (see also Felitti et al., 1998; Whitfield, 1995, 1997b).

well as dissociative amnesia and dissociative identity disorder (Brown et al., 1999; Briere, 1997; Briere and Conte, 1993; Ross et al., 1990). Given the potential for coexisting psychiatric disorders in this population, treatment providers should not rely only on self-assessment tools and patient feedback.

Neuropsychological Consequences Of Childhood Abuse

Clients will benefit from understanding how severe and chronic physical, emotional, and sexual abuse in childhood can affect their memory and emotions long after the abuse has ceased. The long-term consequences of physical battering, for example, might include minimal or severe brain damage (from learning disabilities to mental retardation), aggressive behavior and lack of impulse control, and physical limitations. Childhood abuse or neglect also may hinder the development of a mature personality, because it becomes difficult for the abused person to develop a healthy sense of self. These effects have the potential to seriously complicate substance abuse treatment.

New neuroimaging techniques—such as positron emission tomography (PET) scans or functional magnetic resonance imaging (MRI)—

have revealed that chronic abuse may actually affect pathways in the brain and alter thinking processes. Some studies show reductions in the volume of the hippocampus, the seat of long-term memory, in both combat veterans with PTSD and women with PTSD who experienced severe sexual abuse during childhood (Bremner et al., 1995; Gurvitz et al., 1995; Stein et al., 1997). In another study (Rauch et al., 1996), individuals reliving abusive episodes had marked decreases in blood flow to the left brain—most notably to Broca's area, which governs language capacity—and increased blood flow to the amygdala and limbic system, believed to be the site of emotion and long-term memory. These findings suggest that remembering trauma can produce intense emotional states while at the same time it inhibits individuals' capacity to verbalize their experiences (van der Kolk, 1996).

Counselors should be aware that clients may not be able to verbalize feelings when experiencing intense emotional states. Behavioral treatments such as exposure and desensitization in a safe therapeutic environment should help clients progressively manage these states without losing the ability to communicate. In this way, clients will be able to verbalize feelings instead of experiencing upsetting symptoms in response to traumatic triggers.

Dissociation

Many researchers and counselors now believe that dissociation is a common and readily available defense against childhood trauma, since children dissociate more easily than adults (Turkus, 1998). To defend against abuse, the child psychologically flees (dissociates) from full awareness. Under severe trauma, especially if inflicted at a young age, parts of the self may split off, in some cases creating a compartmentalized way of experiencing the world, with strong or painful emotions and memories shut off from consciousness. These emotions may surface as intense fear or anger when the client is under stress or is in situations that trigger memories of the abuse. In extreme cases, parts of the self may assume separate identities.

Dissociation serves many purposes. It provides a way out of an intolerable situation, it numbs pain, and it can erect barriers (i.e., amnesia) to keep traumatic events and memories out of awareness. The child may begin by using the dissociative mechanism spontaneously and sporadically (Courtois, 1988). With repeated victimization, it may become a chronic defensive pattern that persists into adulthood, resulting in a dissociative disorder. Arising as a survival mechanism to protect the child, over time dissociation changes into a pattern of behavior that interferes with the individual's daily functioning and ability to interact with others. Sometimes these dissociative periods can last hours and require emergency psychiatric treatment.

The counselor may see symptoms of dissociation but be unaware of the cause. For example, the client may "space out" when talking to the counselor, appearing disoriented or forgetful in order to avoid an intimate (and seemingly threatening) situation. The client may be temporarily unresponsive to conversation or questions, although he may reengage if the counselor persists in seeking his attention (Briere, 1989). These periods of disengagement usually last only a few seconds or minutes. However, they may cause the client to miss important insights or opportunities for self-examination.

The client may also report or exhibit intense moods that are out of proportion to the present situation. Rage, terror, overwhelming sadness, or self-destructive impulses may take hold of the client as a result of what may appear to be minor issues, and the client may seem unable to respond to the counselor's attempts to reason with the client.

Because there can be many causes of such extreme emotional reactions, it is important to isolate the symptoms of dependency or withdrawal from those caused by trauma resulting from childhood abuse.

Dissociative symptoms can mimic the effects of drugs or of withdrawal from drugs, making it difficult to determine the type of problem being presented. In victims of trauma, substance abuse itself can be seen as a method of dissociating for those who cannot do it successfully through other means. For this reason, it is common for survivors of child abuse to self-medicate with substances, thus beginning a process that often leads to substance abuse and dependence.

Counselor Issues

Any counselor or treatment provider who might be screening for and assessing histories of child abuse or neglect must receive specific training in these issues. The screening process and followup sessions will invariably involve listening to traumatic stories. Not all treatment providers will be comfortable hearing about their clients' experiences of abuse. Some may experience vicarious trauma or feel overwhelmed by these painful personal accounts. This may be especially true among counselors whose own traumatic childhood experiences were not addressed therapeutically. The counselor's biases from these experiences, regardless of their similarity to a client's, could have a harmful impact. If counselors experience intense discomfort and anxiety when conducting screenings and assessments, the Consensus Panel recommends that they receive guidance and support from a clinical supervisor and consider whether they could benefit from therapeutic assistance to explore the reasons for their discomfort. (For a more detailed discussion on counselor issues, see Chapter 4.)

Prior training on handling abuse issues can help counselors "screen" themselves to recognize if they are unprepared to work with clients who have experienced childhood abuse or neglect. It is better to find out ahead of time than for the counselor to risk damaging the therapeutic process by having to confront personal issues in the middle of it—possibly even ending the session prematurely, leaving the client confused, feeling abandoned, or wondering "What's wrong with me?" Many counselors avoid issues of childhood abuse simply from lack of experience. They need assurance that the proverbial can of worms that has been opened can be closed in a reasonable length of time. Proper training can help counselors better deal with trauma and with secondary PTSD, sometimes known as "compassion fatigue."

Screening for a History of Child Abuse or Neglect

Because adults who were abused or neglected during childhood can experience significant trauma-related consequences that require clinical intervention, the Consensus Panel suggests using child abuse and neglect screening (1) to identify individuals who exhibit certain signs and symptoms associated with child abuse and neglect (such as PTSD, major depression, or mood disorders) and (2) to identify who may benefit from a comprehensive clinical assessment. Consequently, treatment staff should

- Learn and understand ways in which childhood abuse and neglect can affect adult feelings and behaviors
- Identify those individuals who appear to exhibit these symptoms
- Identify the trauma-related treatment needs of these clients
- Provide or coordinate appropriate treatment services that will help to meet clients' treatment needs

The Need for Screening

Adults who were abused as children are more likely to use drugs or alcohol (Dembo et al., 1989; Singer et al., 1989; Zierler et al., 1991); therefore, they are more likely to be in treatment for substance abuse.

The consequences of childhood abuse and neglect can dramatically affect a client's treatment needs. For instance, as noted in Chapter 1, a history of childhood trauma can increase the number and intensity of treatment services required, lengthen the time needed for treatment, and increase the number of sessions, particularly for male clients (Downs and Miller, 1996; Felitti, 1991; Felitti et al., 1998; Steinglass, 1987; Young, 1995). The consequences of childhood abuse and neglect can also affect the psychosocial supports that such clients may need following treatment (Steinglass, 1987). Screening for childhood abuse or neglect can set in motion a proactive plan with the following benefits:

- *Stopping the cycle.* Although not all adults who were abused or neglected during childhood abuse their own children, they are at greater risk of doing so (Kaufman and Zigler, 1987). Thus, screening for abuse and neglect can be an important step in stopping the cycle of abuse in many families.
- *Decreasing the probability of relapse.* Many substance abusers use alcohol and illicit drugs to self-medicate posttraumatic stress symptoms related to past physical or sexual abuse or trauma (Price et al., 1998); clients may abuse substances to deal with hyperarousal or stress (Clark et al., 1997; De Bellis, 1997). Since these are important causes of continued substance-abusing behavior, addressing them may facilitate treatment and reduce relapse.
- *Improving a client's overall psychological and interpersonal functioning.* Childhood sexual abuse and neglect may affect the individual's self-concept, sense of self-esteem, and ability to self-actualize. They also affect a person's ability to trust, be intimate, and set limits with others. Identifying a history of abuse or neglect enables the client to address these issues as they relate to overall functioning as well as to recovery. The ability to trust is especially important; difficulties with trust can impede the client's ability to utilize treatment to its fullest.
- *Improving program outcome.* Screening for a history of child abuse or neglect helps to determine the percentage of abused and neglected individuals who are in a substance abuse treatment program. Furthermore, screening, combined with assessment, helps to determine the trauma-related treatment needs of clients. With this information, programs can make informed decisions about providing the treatment services that can best meet their clients' needs.

When Should Screenings Be Conducted?

Clients' treatment needs change over time. For this reason, counselors must conduct ongoing assessments of their clients' problems, including substance abuse, health concerns, psychological problems, family-related stressors, parenting stressors, interpersonal stressors, social support, and vocational problems. Having up-to-date information allows counselors to deliver individualized treatment to each client that meets specific needs and is of the appropriate length and intensity.

As with psychosocial evaluations, screenings for child abuse and neglect should be conducted early in a comprehensive assessment process. However, because denial and minimization are prominent defense mechanisms associated with childhood trauma and trauma survivors may feel shame and discomfort answering abuse-related questions, screenings should also be conducted at different times throughout the treatment process. Repeated screenings help elicit information about these traumatic experiences—especially after trust has been established in the therapeutic relationship. Treatment providers should be aware, however, that repeated screenings may give the impression that the therapist does not believe the client. For clients who typically were disbelieved as children, this can be an important therapeutic issue. Furthermore, cognitive and memory impairment caused by substance abuse decreases with length of sobriety; that is, over time, a client may *physiologically* be more capable of recalling past experiences if she maintains sobriety (Leber et al., 1981; Reed et al., 1992).

Who Should Conduct Screenings?

The Consensus Panel believes that treatment decisions and activities are best conducted within the context of a multidisciplinary treatment team, with members having special knowledge in such areas as mental health, child abuse and neglect, and family counseling. Team members should possess varied levels of training and experience. At the same time, there are different types of treatment settings, including drop-in centers, residential treatment programs, and intensive and less intensive outpatient and hospital-based programs. These varied treatment settings and the composition of the treatment team will affect screening decisions, including who is available to conduct them.

Although there are no rigid rules regarding who should conduct screenings, having certain skills will increase the likelihood that the screening process is conducted appropriately. Irrespective of the level of academic credentials, training, supervision, or specific role within the treatment team, treatment staff members should all have an understanding of the types of psychiatric disorders and symptoms that are commonly associated with a history of childhood abuse and neglect (see Figure 2-1 above). They should understand the role of screening and assessment for a history of trauma, and they should know the types of questions that constitute a screening for child abuse and neglect. Moreover, they should have developed a sensitivity to the issues of child abuse and neglect.

Training and supervision

No one should screen for childhood trauma without specific training and supervision. The Consensus Panel strongly recommends that counselors administering the screening understand the reasons for conducting the screening, be knowledgeable about the best practices for screening, and receive training in conducting the screening in an empathic manner. They also should understand the assessment and treatment processes that may follow a positive screening and be able to explain these processes to the client.

Counselors who conduct screenings will be prompting clients to recall painful and traumatic events. The reemergence of painful memories may prompt intense reactions from clients. Clients may feel drained or distraught afterwards. Treatment staff should be sensitive to this and prepare for the interview in the following ways:

- Clients should be informed that talking about such issues may create discomfort and that repressed memories may emerge unexpectedly following the interview. Clients should be given a choice to disclose such information, being aware of the possible aftermath.
- Counselors should have proper supervision and support mechanisms in place for clients in case a crisis occurs following disclosure. As well as clinical support, this includes having appropriate mental health practitioners available in case further intervention is necessary.
- Counselors should assess the social and emotional support available to clients when

they return home. If necessary, the staff can help the client find transportation home after the screening and then follow up with a telephone call to offer support or help if needed.

Types of Screenings

When screening for histories of child abuse or neglect, counselors ask clients a series of questions designed to elicit information about childhood trauma. Screenings can be informally divided into two types: direct questions and standardized screenings. Direct questions are asked to obtain confirmation of a history of child abuse and neglect. Standardized screenings are structured sets of questions that are designed to determine the possible presence of past child abuse.

Both direct trauma questions and standardized screenings can be embedded within larger psychosocial assessments. Indeed, all clients receiving screenings for childhood abuse and neglect should be evaluated for symptoms of other mental health problems. When a client denies having a history of child abuse or neglect but presents symptoms commonly associated with childhood trauma, treatment staff may need to expand their assessment process to include a more thorough evaluation of the client's childhood experiences and behavioral responses to traumatic events. This information may be useful in understanding the origins of some of the client's current mental health problems.

Direct trauma questions

Some trauma questions inquire directly about childhood abuse and neglect experiences. Depending on the setting (e.g., inpatient, residential, long-term therapy), expertise of the staff, and other factors, this approach has been used successfully in eliciting the information being sought. Other questions, however, will be about circumstances and experiences that are often associated with and suggest a history of childhood abuse or neglect; for example, "Did you ever live away from your parents?" and, "Were you ever in foster care?" Figure 2-2 lists questions that can be used to conduct a screening for a history of childhood abuse or neglect.

Standardized screening instruments

Several instruments can be used to elicit a history of child abuse or neglect; five are reviewed below. Some are specifically designed to collect information about interpersonal traumatic experiences in childhood. Others are designed to collect information on a broader topic, such as general mental health or substance abuse but include a subsection on childhood trauma. These tools differ widely with regard to primary purpose and level of detail elicited.

The Consensus Panel has included the following tools for practitioners' review and possible use. Treatment staff should note that the Childhood Trauma Questionnaire and the Trauma Symptom Checklist-40 are new, are not well validated, and are used primarily as research tools.

Information about obtaining the instruments listed below is provided in Appendix D. See also the Childhood Maltreatment Interview Schedule (CMIS) and other trauma-oriented tools described later in this chapter. If these measures are used with non–English-speaking clients, the translations must be appropriate and carefully applied (e.g., sensitive to the differences between Spanish used by Puerto Ricans, Mexicans, and other Latinos).

Addiction Severity Index (ASI)

The fifth edition of ASI is a 161-item multidimensional structured clinical interview designed to collect information about substance abuse and client functioning in various life areas for adults seeking treatment for substance abuse (Fureman et al., 1990; McLellan et al., 1990). The ASI is frequently used during intake in treatment programs. It includes three questions

Figure 2-2

Direct Questions To Screen for a History of Childhood Abuse or Neglect

The following questions can be used to help screen for a history of childhood abuse or neglect. They can be asked as written. However, they can also be asked in relation to developmental stages. To do so, ask the same question with a different introductory phrase that reflects different time periods or developmental stages. For example, the basic question "Were you treated harshly as a child?" can be rephrased as, "When you were 5 to 10 years old, ..." or, "When you were 11 to 15 years old, ..."

Questions about trauma events include:

Were there any significant traumatic events in your family while you were growing up? For example, did any of the following events occur in your family: death of a parent or sibling, hospitalization of a parent or sibling, incarceration of a parent or sibling, divorce, or chronic disease?

Were you treated harshly as a child?

Did you ever experience physical, sexual, or emotional abuse as a child?

Did you experience inappropriate physical or sexual contact with an adult or person at least 5 years older than you while you were growing up?

When you were a child, was there violence in your household, such as battering of family members, involving siblings or a parent and his or her partner?

Do you feel that your parents neglected you while you were growing up? For example, were there ever periods during which you did not have adequate food, clothing, shelter, or protection by your parents?

Did your parents use alcohol or drugs frequently when you were growing up? Did you ever use alcohol or drugs with them?

Questions about circumstances that may suggest traumatic events:

Have you or has anyone in your family ever been involved with the child protective system?

Did you ever live away from your parents? Were you ever in foster care? Were any of your siblings ever in foster care?

When you were a child, were there any periods when you felt unsafe or in danger?

When you were growing up, did anyone in your family use alcohol or drugs? How did their alcohol or drug use affect you as a child?

Have you ever felt that abuse or neglect was justified based on your misbehavior or shortcomings? (In other words, did the client feel that the abuse was her fault and that she deserved it?)

that are used to elicit information about a history of childhood abuse. It inquires about episodes of emotional, physical, or sexual abuse in relation to several people (e.g., mother, father, brother/sister, sexual partner/spouse, children). The questions are not childhood-specific, and preliminary research suggests that the ASI trauma questions show stronger utility as a screen for PTSD than for childhood trauma (Najavits et al., 1998). The female version of ASI has an additional question about sexual harassment (CSAT, 1997c). The National Institute on Drug Abuse (NIDA) has developed an ASI package that includes an introductory brochure, handbook for program administrators, resource manual, two videotapes, and training manual (NIDA, 1993).

Childhood Trauma Questionnaire (CTQ)

CTQ is a 10- to 15-minute questionnaire that provides a brief and relatively noninvasive screening of childhood traumatic experiences (Bernstein et al., 1994). The 28-item retrospective self-report evaluates physical, sexual, and emotional abuse; physical and emotional neglect; and related areas of family dysfunction, including substance abuse. It includes a minimization/denial scale for detecting individuals who may be underreporting traumatic events. This screening tool is notable for the brevity of administration, range of coverage, and availability of psychometric data (Briere, 1997). Limitations include the absence of specific items regarding characteristics of the maltreatment and lack of information regarding age range for traumatic events (Bernstein et al., 1994; Briere, 1997).

Parent-Child Relationship Inventory (PCRI)

PCRI is a 78-item self-report questionnaire designed for clinical use. PCRI assesses six areas of parenting, including parental satisfaction, support, involvement, communication, limit setting, and autonomy. The measure also includes a validity scale that will indicate if the client is responding defensively or randomly. The PCRI handbook provides clear guidelines for interpreting scores on each scale and identifying areas of risk (Gerard, 1994).

Parental Acceptance and Rejection Questionnaire (PARQ)

PARQ is a brief self-report questionnaire designed to assess individuals' perceptions of their childhood experiences of love and love withdrawal in relation to their mothers and fathers. PARQ elicits information concerning affection, hostility, neglect, and undifferentiated rejection. It has been used and evaluated with many ethnic and cultural groups in the United States and in numerous countries on several continents. Different versions of PARQ are included in the *Handbook for the Study of Parental Acceptance and Rejection* (Rohner, 1990). The handbook, which summarizes parental acceptance and rejection theory and evidence, provides information about PARQ and about using, scoring, and interpreting this self-report. This measure, however, has no validity scale.

Screen for Posttraumatic Stress Symptoms (SPTSS)

SPTSS is a brief, 17-item self-report tool used to screen for PTSD symptoms; it is especially useful for clients with histories of multiple traumatic events or whose trauma history is unknown (Carlson, 1997). SPTSS yields a total score that is the average of the individual item scores. The item scores can be used to make a provisional assessment regarding whether clients' symptoms meet DSM-IV criteria for PTSD. It takes approximately 5 minutes to complete.

Trauma Symptom Checklist-40 (TSC-40)

TSC-40 is a 40-item self-report tool that evaluates symptomatology in adults resulting from childhood or adult traumatic experiences (Elliott and Briere, 1992). TSC-40 (an expanded version of the Trauma Symptom Checklist-33) consists of six subscales, which evaluate such things as anxiety, dissociation, and sexual concerns (Briere and Runtz, 1989). Both TSC-40 and TSC-33 have moderate predictive validity regarding a wide variety of traumatic experiences (Briere and Elliott, 1993).

Formal Assessment for a History of Child Abuse Or Neglect

Whether identified during intake or in the context of a subsequent psychosocial assessment, a positive screening for childhood abuse or neglect alerts the treatment provider that more information about the trauma is needed and that a thorough and comprehensive childhood abuse and neglect assessment is warranted. Thus, the primary purpose of an assessment is to confirm or discount a positive screening for childhood abuse or neglect. At the same time, it is an opportunity to evaluate clients' trauma-related treatment needs. In general, the more clinical information that a program has about clients' particular treatment needs, the better the program can meet them. Under optimal circumstances, all clients who screen positive for a history of childhood abuse or neglect should be offered a comprehensive mental health assessment.

CPS case managers and court and law enforcement personnel may already be conducting their own screenings and assessments. Some systems (such as in Massachusetts) provide multidisciplinary assessments of client families to avoid duplication and to provide a more comprehensive service-planning product.

When Should Assessments Be Conducted?

When deciding whether to conduct assessments for a history of child abuse or neglect, thoughtful consideration should be given to the following issues: substance abuse, client readiness, input from all team members, and family involvement.

Substance abuse issues

The treatment team should evaluate (1) clients' current substance abuse, (2) clients' commitment to the treatment and recovery process, (3) the quality and length of abstinence, and (4) clients' risk of relapse. Treatment staff should make these evaluations on an individual basis and not translate them into a rigid protocol. For example, a client in the early phases of treatment who is struggling to make a commitment to abstinence but who has not yet developed significant psychosocial supports for abstinence may be at risk for relapse if he attempts to address childhood abuse issues. (Even so, in some cases the client may be at higher risk if he does not address these issues.) On the other hand, a client who has achieved a few years of abstinence and has a strong commitment to abstinence, but who recently relapsed when her father made threatening phone calls to her, may be psychologically prepared to explore her childhood abuse issues while simultaneously strengthening her recovery program.

Client readiness

Throughout substance abuse treatment and through the multiple psychosocial assessments and screenings for childhood abuse and neglect, the treatment team can gain valuable information about clients' childhoods. Indeed, treatment staff may have enough information to confirm clients' histories of childhood abuse and neglect. Staff may have also observed behavioral, emotional, and psychiatric manifestations of the childhood trauma. However, unless a formal assessment has been conducted, the staff probably will not have a thorough understanding of the details, context, and severity of these traumatic events, or the childhood responses to them. Similarly, unless they inquire, staff will not know whether clients (1) recognize themselves as having experienced abuse or as being affected by such abuse, (2) believe that they are ready to confront these issues and are willing to do so, and (3) believe they can handle the consequences without jeopardizing treatment. Thus, staff members should ask clients to evaluate their own readiness for confronting child abuse or neglect issues.

At this point, staff should also know something about clients' current family situations and can work with them to identify who is safe to involve or to provide support. Some adults in treatment regress to a state of dependence on their parents—parents are caring for grandkids, parents are paying for treatment, parents are the only housing resource after institutional treatment or incarceration. Abuse is a family issue; its disclosure and the client's treatment may well disrupt family dynamics and trigger denial—consequences of particular concern to a dependent adult client.

Input from all team members

Each member of the treatment team should have a voice in deciding if and when to conduct assessments for childhood trauma. Each member will bring a different but valuable perspective about a client's progress in treatment, risk of relapse, and readiness to address childhood trauma. Individual team members can also contribute to discussions about the client's commitment to treatment and recovery, her psychosocial supports, her current family situation, and any significant issues that may need to be resolved quickly.

Involving the family

Counselors hold different opinions on when and how much to involve the family in a client's treatment, but all agree there are many risks involved that must be carefully weighed against the potential benefits. This is especially true at the assessment stage, which usually occurs early in the treatment process when it is critical to get accurate information and to establish a relationship of trust with the client. Of foremost importance must be the client's opinion about whether to involve family members, and which ones. It is a good idea to obtain the client's written permission before contacting family; some counselors will only call a family member with the client present. (Although the client's current or "chosen" family is likely to be more supportive and should be encouraged to be involved, these persons may have less direct knowledge of the client's history of childhood abuse or neglect.)

Most abuse occurs within the family. For this reason, complicated dynamics of denial, complicity, guilt, and fear of retribution may still be in place long after the client and his siblings have become adults. Grandparents, too, may be ashamed that they did not or could not protect the victim—or may themselves have been perpetrators. Family members may resent the client for opening up old wounds, exposing a family secret, or forcing them to confront a situation they may have tried to pretend did not happen. It is important to protect the client from the possibility of revictimization (Hansen and Harway, 1993).

Family members can sometimes be valuable participants in the assessment process; however, counselors must maintain client rights of confidentiality. (For more information on confidentiality, see Appendix B.) Spouses and significant others can be sources of information, especially about the current situation. Grandparents can shed light on intergenerational patterns of family trauma and violence. Siblings can often provide useful information about the family, such as intrafamilial violence during the client's childhood. Because of differences in personality, age, and development, siblings will often have different perspectives and even disagree about traumatic events that occurred during childhood. Also, the family environment and dynamics may have been different for different siblings. For a more detailed discussion about involving families, see the "Involvement of the Family in Treatment" section of Chapter 3.

Who Should Conduct Assessments?

A multidisciplinary team should conduct a full assessment, although many assessment tools require professional training to conduct and interpret—the type of training specifically provided to clinically licensed psychologists, psychiatrists, and psychiatric social workers. (Many assessments also can be conducted by marriage and family therapists and licensed professional counselors.) A full assessment involves confirming diagnoses, which should be done only by mental health professionals. Similarly, assessing histories of childhood trauma can provoke or exacerbate a psychological or psychiatric emergency, which must be addressed; a psychologist, clinical social worker, or psychiatric nurse can handle most situations. If clients have active and severe symptoms of depression, suicidality, severe anxiety, or other psychiatric crises, and issues of medication or hospitalization arise, clients should be evaluated immediately by a psychiatrist.

For these reasons, the Consensus Panel recommends that the treatment team include a licensed mental health professional for more formal assessments that may be required. This individual should have training in childhood trauma, the effects of childhood trauma on adults, and the different tools that can be used to assess trauma, as well as having the clinical and licensing requirements for making diagnoses. The licensed mental health professional can also provide guidance, training, supervision, and crisis intervention throughout the assessment process.

Licensing issues

Some funding and administrative agencies (e.g., third-party payors) require that a physician certified by the American Society of Addiction Medicine (ASAM) make diagnoses. State laws vary regarding the licensing and training of mental health professionals and who can conduct assessments and make diagnoses. All team members should have a good understanding of the relevant regulations and requirements.

Clinical Trauma Assessment

To identify clients' trauma-related treatment needs, the treatment team should gather information about the traumatic events and how clients responded to them. These two areas of interest correspond to the two primary domains of assessment inquiry: (1) assessment of childhood traumatic events and experiences and (2) assessment of current mental health, especially symptoms and syndromes that may relate to childhood trauma. To increase the usefulness of this information, the evaluation should incorporate a developmental perspective—that is, perception of the trauma at different ages (Gussman et al., 1996). Not all clients with a history of child abuse or neglect will see it as a problem or view themselves as victims or as "damaged" by the experience. Treatment providers should be careful not to use labels that some clients may resist or be uncomfortable with.

Significant traumatic events

The goal of the assessment process is to identify clients' needs so that treatment can be provided to meet them. To treat the aftermath of childhood trauma, the treatment team should identify, in as much detail as possible, the traumatic events that occurred. The trauma-related assessment is an opportunity to systematically assess the details and context of the victimization experience. Examples of event-specific information that are gathered include

- Type of abuse
    - Physical abuse
    - Sexual abuse
    - Psychological abuse
    - Exploitation
    - Exposure to domestic violence
    - Neglect

- Evidence of multiple types of abuse (concurrent or serial)
- Relationship to the perpetrator (who may be a relative, stranger, teacher, or caregiver)
- Frequency of abusive events
- Duration of the abuse
- The victim's age at onset and cessation of the abuse
- Context of the trauma, including presence of force or fear
- Whether the family knew about the abuse
- Response of the family to the abuse
- Response of the social system, including CPS agencies, foster care, or placement with relatives
- Past mental health counseling or other treatment as a child
- How and when the abuse was disclosed
- Social consequences of the abuse
- Legal consequences of the abuse

Subjective experience of the events

In addition to gathering event-specific details, assessing childhood trauma also involves eliciting information over time about the subjective experience of these events. How clients remember a traumatic event can shape the psychological response more than the actual circumstances. For this reason, childhood trauma assessments in clinical (as opposed to forensic or research) settings focus on obtaining qualitative information about traumatic experiences and responses. Subjective and qualitative details about traumatic events—such as recollections and perceptions—are needed to plan and provide appropriate treatment for a client (Carlson, 1997). However, some clients may strongly resist these questions; others may become very upset and need immediate support from a mental health professional.

Useful subjective information can include the following:

- What was the client thinking about during the abuse?
- What was the client feeling during the abuse?
- As a child, how did the client understand what happened to her and what does she think about it now?
- How does the client think and feel about how the abuse affected her adulthood and substance abuse; how does the client deal with the aftereffects of the abuse now?
- What feelings are most associated with the abuse experience?
- What are the client's memories about the abuse?
- What are the client's unique perceptions about the abuse?
- What coping strategies does the client use? How effective are these?

Childhood symptoms and family characteristics

Because the primary purpose of the trauma assessment is to validate or discount a positive screening for childhood trauma, the assessment should inquire about childhood symptoms and family characteristics that are consistent with and suggest a history of childhood abuse or neglect. Childhood symptoms and behaviors to consider include

- Depression (including thoughts of death, passive suicidal ideation, and feelings of hopelessness)
- Dissociative responses during childhood
- Aggressive behavior or other "acting out," including
  - Early sexual activity or sexualized behavior
  - Physically abusing or harming pets or other animals
  - Other destructive behaviors
- Poor relationships with one or both parents
- Attachment disorder, difficulty trusting others
- Excessive passivity
- Passive/aggressive behavior, including
  - Failing school grades

    - Poor sibling relationships
    - Obesity or anorexia
- Inappropriate age/sexuality formation
- Blacked-out timeframes in childhood
- Excessive nightmares, extreme fear of darkness, or request for locks on doors

Family-of-origin characteristics to consider include

- Parental substance abuse
- Battering within the family
- Involvement with CPS agencies or foster care
- Placement with foster parents or relatives
- Severe discipline during childhood
- Traumatic separations and losses

General mental health symptoms

The second area that can be evaluated through trauma-related assessments is the current general mental health of clients, paying special attention to symptoms that may be related to child abuse and neglect. These evaluations focus on the cardinal responses to trauma.

Posttraumatic stress symptoms

After a highly distressing or traumatic event, individuals may exhibit posttraumatic stress symptoms. These symptoms include persistent reexperiencing of the traumatic event through intrusive thoughts or nightmares, a numbing of responsiveness to or avoidance of current events, and hyperarousal, such as difficulty sleeping, poor concentration, irritable outbursts, jumpiness, or hypervigilance. Clients with PTSD are frequently so preoccupied with their traumatic experiences that they have trouble focusing on substance abuse problems. They may also have severe difficulties in social, economic, vocational, and marital adjustment (Daley et al., 1993) that are not directly related to their substance abuse.

Dissociation symptoms

Children and adults who have been traumatized may experience symptoms of dissociation. Dissociation can be defined as the disruption of the usually integrated functions of consciousness, memory, identity, and perception (Putnam, 1997). As described above, dissociation is the disconnection from a full awareness of self or external circumstances. Symptoms of dissociation include excessive daydreaming, a severe numbing of emotions, out-of-body experiences, and amnesia of painful abuse-related memories (Brown et al., 1999; Briere, 1992a, 1995). Individuals may also exhibit severe behavioral regressions, such as curling up into the fetal position, or exhibit different intense mood states, such as anger or fear, when discussing their childhood abuse. These periods of disengagement usually last only a few seconds or minutes, but they can last for hours (Whitfield, 1997b). As noted earlier, for some clients substance abuse may serve the same function as dissociation (i.e., self-medication to escape the effects of childhood trauma). It is not clear whether dissociative symptoms increase for these clients once sobriety is achieved. Counselors are advised to monitor any such increases in these symptoms.

Most common responses to trauma involve the reexperience or avoidance of trauma-related experiences (Horowitz, 1976; van der Kolk, 1987). Reexperience-related symptoms include intrusive thoughts, anxious and angry feelings, physiological arousal and reactivity to trauma triggers, and hypervigilance (Carlson, 1997). Avoidance-related symptoms include the avoidance of thoughts, feelings, conversations, activities, places, people, or memories associated with the trauma (American Psychiatric Association [APA], 1994). Figure 2-3 illustrates the common responses to trauma organized by biopsychological domains and divided into symptoms that represent either reexperiencing or avoidance.

Adult clients with a history of childhood abuse and neglect may have a loss of previously sustained beliefs, may feel permanently damaged and hopeless, and may experience

Figure 2-3

Common Responses to Childhood Trauma Among Adults

Domain	Reexperiencing-Related Responses	Avoidance-Related Responses
Cognitive	■ Intrusive thoughts ■ Intrusive images	■ Amnesia ■ Derealization/depersonalization ■ Dissociation
Affective	■ Anger ■ Anxiety/nervousness ■ Depression ■ Shame ■ Hopelessness ■ Loneliness	■ Emotional numbing ■ Isolation of affect
Behavioral	■ Increased activity ■ Aggression ■ High tolerance for inappropriate behavior	■ Avoidance of trauma-related situations (e.g., through sleep, substance abuse)
Physiological	■ Arousal—autonomic hyperreactivity to trauma triggers	■ Sensory numbing ■ Absence of normal reaction to events
Multiple domains	■ Flashbacks ■ Age regression ■ Nightmares	■ Complex activities in dissociated states

Source: Adapted from Carlson, 1997; also Whitfield, 1997b.

shame. They may have personality and relational disturbances and may be hostile, self-destructive, and impulsive. They also can have somatic symptoms, such as headaches, stomach pain, asthma, and chronic pelvic pain (Felitti, 1991; Herman, 1993). Clients with histories of childhood trauma will often have multiple symptoms, which can be acute, recurring, and chronic. The multitude of problems will make diagnosis difficult. The assessor may interpret the manifestations as PTSD or a personality disorder.

Irrespective of theoretical orientation, assessors will find it helpful to look at their clients' symptoms through a developmental perspective. This approach involves a careful review of the client's history, beginning with the client's description of her family and early childhood. The assessor can probe for information about abusive or neglectful episodes during the client's childhood, adolescence, and adulthood. From this history, a picture will emerge of the client's evolving feelings and behaviors. This will help to clarify how some of the client's present behaviors and problems have developed over time. Even though the counselor cannot undo the historical facts, this knowledge about the client's past will help explain some of the reasons for her current difficulties.

Assessment Tools

As mentioned earlier, trauma-related assessments involve evaluating childhood traumatic events and gauging the individual's responses to these events. In the treatment setting, the two primary groups of assessment tools are general mental health assessment tools and trauma-oriented tools. Given the tendency of some victims of child abuse to become abusers themselves, treatment providers should also consider using some domestic violence screening tools as well. (See TIP 25, *Substance Abuse Treatment and Domestic Violence* [CSAT, 1997b], especially pp. 115–126.) The section "Special Considerations and Recommendations" at the end of this chapter provides some guidelines for policy and selection concerning the instruments discussed below.

Both groups of tools include self-reports and structured interviews. Self-reports are typically pen-and-paper questionnaires that clients fill out. They are often free or inexpensive and take only a short time to complete. They also may elicit greater levels of disclosure than clinician-led interviews since clients may be less inhibited in written self-reports (Newman et al., 1996). Such qualities make self-reports a good choice for a first step in the assessment of traumatic experiences and responses (Carlson, 1997).

Structured interviews consist of an organized and preestablished set of questions the assessor poses to clients in a face-to-face interview. As a result, structured interviews allow assessors to observe clients' affective responses to questions and their method of interpersonal interaction. Structured interviews are especially useful in eliciting detailed information, both qualitative and quantitative, about the clients' experiences and symptoms. Because they involve a set of predetermined questions and preestablished areas of inquiry, structured interviews can eliminate some clinician biases, such as a clinician's desire to avoid areas of discomfort. Although there is substantial variation among structured interviews, they are typically time limited, efficient, and comprehensive. Furthermore, interviews reach those clients who are marginally literate. This condition may not be obvious to the counselor at the assessment stage. Information on where to obtain most of the tools discussed below is provided in Appendix D.

General mental health assessment tools

An important task of trauma-related assessments is to help the treatment team gain an understanding of clients' general mental health and to determine whether clients have psychiatric symptoms or syndromes commonly associated with childhood abuse or neglect, especially posttraumatic stress symptoms and dissociative symptoms. In addition to the structured interview and self-report formats, general mental health assessment tools can be more traditional psychological tests and inventories.

Mental health self-reports

The purpose of self-reports for general mental health evaluation is to elicit from clients their own understanding of their mental health symptoms. These self-reports are inexpensive and efficient. They can be rapidly completed in a clinical setting, and they can be used to complement clinical assessments, including interview-based assessments.

Some mental health self-reports are global and evaluate the general mental health of clients. For example, the Symptom Checklist-90-Revised (SCL-90-R) and the shorter version called the Brief Symptom Inventory address nine symptom dimensions of mental health. In contrast, some mental health self-reports evaluate specific areas of mental health. For example, the Profile of Mood States focuses on affective and emotional functioning, and the Beck Depression Inventory focuses on depression.

Beck Depression Inventory (BDI)

BDI is a 21-item scale designed to measure the severity of depression by assessing the presence and severity of affective, cognitive, motivational, vegetative, and psychomotor components of depression (Beck, 1967). BDI is one of the most widely used measures of depression in clinical practice. Substantial research has been conducted to evaluate BDI's reliability, validity, and utility. A short, 13-item version of the BDI is also available and has good concurrent validity with the long form (Beck and Beck, 1972; Gould, 1982).

Brief Symptom Inventory (BSI)

BSI is a short form of SCL-90-R and is designed to reflect the psychological symptom patterns of psychiatric and medical clients (Derogatis, 1992; Derogatis and Spencer, 1982; Derogatis et al., 1973). BSI takes approximately 10 minutes to administer and has 53 items. It evaluates the same nine symptom dimensions as SCL-90-R and includes measurements of the severity of the disorder, the intensity of symptoms, and the number of client-reported symptoms. Because of its brevity, it can be used in initial assessments, as part of a test battery, and for monitoring client progress. More than 300 studies have evaluated the reliability, validity, and utility of BSI.

Profile of Mood States (POMS)

POMS is a 65-point objective rating scale designed to measure six identifiable mood states (McNair et al., 1992). POMS measures tension/anxiety, depression/dejection, anger/hostility, vigor/activity, fatigue/inertia, and confusion/bewilderment. It is primarily used as a measure of mood states in psychiatric outpatients and as a measure for assessing changes in those clients. POMS elicits information regarding mood states in the week prior to administration of the assessment.

Symptom Checklist-90-Revised (SCL-90-R)

This is a brief, multidimensional inventory designed to screen for a broad range of psychological problems and symptoms of psychopathology (Derogatis, 1994; Derogatis and Spencer, 1982). SCL-90-R takes approximately 15 minutes to administer and contains 90 items. It measures nine primary dimensions of mental health: somatization, obsession–compulsion, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. It includes measurements of the severity of the disorder, the intensity of symptoms, and the number of client-reported symptoms. It is a useful tool to measure treatment progress. Extensive research has been conducted to evaluate the tool's reliability, validity, and utility.

Structured mental health interviews

There are several structured interviews that elicit general mental health information. They are used as the framework for a systematic review of the client's mental health, in particular to explore whether clients have psychiatric symptoms or syndromes associated with childhood abuse or neglect. Thus, while structured mental health interviews may be comprehensive and explore multiple domains of mental health, when used in the context of evaluating a history of childhood trauma these tools are especially valuable for systematically reviewing whether there are symptoms of posttraumatic stress or dissociation. Typically, structured mental health interviews are grounded in the system laid out in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th Edition (DSM-IV) (APA, 1994).

Diagnostic Interview Schedule (DIS)

The most recent version of DIS, version 4, is designed to elicit data relating to most DSM-IV adult diagnoses on both a lifetime and current basis. Current disorder is defined for four time periods: the last 2 weeks, the last month, the last 6 months, and the last year. Each diagnosis is based on clients' meeting a minimum number of criteria. Since clients need not meet all criteria, individuals may be assessed for the severity of each diagnosis by counting how many of the criteria they meet. Across diagnoses, severity may be determined by the number of different diagnoses present, the total number of symptoms, how many years they have had the symptoms, and the degree of functional impairment. DIS also asks for the age at time of the last symptom, the age at which the first symptom appeared, and whether medical care was ever sought for the symptoms. Virtually all response categories are close-ended and precoded, with explicit instructions. After the interviewer follows these instructions, a computer makes the actual diagnosis. The computer also provides information such as the age of onset and termination of syndromes, the total number of symptoms ever manifested, diagnosis with earliest onset, total number of lifetime diagnoses, and the number of types of current diagnoses (Robins et al., 1981).

Mini International Neuropsychiatric Interview (MINI)

MINI was designed as a brief structured interview to screen for the major psychiatric disorders in DSM-IV (Sheehan et al., 1994). It contains 120 questions covering 17 Axis I disorders from DSM-IV. Unlike longer interviews, MINI focuses on a core set of diagnostic questions for each disorder and considers only those timeframes that are useful in making decisions in clinical settings. MINI has two to four screening questions per disorder with followup questions for positively endorsed screening questions. MINI assesses information regarding major depressive episodes, dysthymia, mania, anxiety disorders, obsessive-compulsive disorder, substance abuse disorders, psychotic disorder, anorexia nervosa, bulimia nervosa, PTSD, suicidality, antisocial disorder, somatization disorder, and attention deficit-hyperactivity disorder. MINI has high validation and reliability scores and can be administered in approximately 15 minutes (Sheehan et al., 1994). A computerized version of MINI is available that can be administered by the client or the paraprofessional.

There is also MINI Plus, which is a more elaborate, detailed structured interview than the shorter MINI. It elicits all the symptoms listed in the symptom criteria for DSM-IV for 24 major Axis I diagnostic categories, one Axis II disorder, and suicidality. It elicits information on the impairment criteria and about the major subtypes of each disorder covered. MINI Plus takes approximately 30 to 45 minutes to administer.

Psychiatric Research Interview for Substance and Mental Health Disorders (PRISM)

PRISM is a psychiatric diagnostic interview designed to produce diagnoses of DSM-IV mental health and substance-related disorders (Hasin et al., 1992, 1996). The PRISM includes a systematic set of procedures for differentiating primary disorders, substance-induced disorders, and the expected effects of intoxication and withdrawal. There are two formats for PRISM. The DSM-IV PRISM assesses for substance dependence and abuse, primary affective disorders, primary anxiety disorders, primary psychotic disorders, eating disorders, personality disorders, and substance-induced disorders. The PRISM-Longitudinal (PRISM-L) is designed for clinical trials that require collected data on the course of mental health and substance abuse disorders over time. PRISM takes between 90 and 150 minutes to administer, depending on the history and response style of the client.

Schedule for Affective Disorders and Schizophrenia (SADS)

SADS provides detailed descriptions of the current episodes of illness, the severity of manifestations of major dimensions of psychopathology, and past psychopathology and functioning relevant to an evaluation of diagnosis, prognosis, and overall severity of disturbance. By using a progression of questions and criteria, it also provides information for making diagnoses (Spitzer and Endicott, 1978). There are various versions of SADS, some of which have been published and widely used.

Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I)

SCID-I is an extremely detailed interview tool that comprehensively reviews all DSM-IV Axis I disorders (First et al., 1997). This comprehensive interview guides clinicians through an evaluation of mood disorders, anxiety disorders, dissociative disorders, cognitive disorders, somatoform disorders, substance-related disorders, psychotic disorders, eating disorders, sleep disorders, impulse-control disorders, adjustment disorders, sexual and gender identity disorders, and factitious disorders, as well as disorders usually first identified in infancy, childhood, or adolescence. SCID-I materials include a clinician version, a 160-page user's guide, an administration booklet, and score sheets. SCID does not have to be administered in its entirety; individual disorder units—for example, those covering depression, substance abuse, and anxiety—can be administered separately. Potentially irrelevant units—for example, schizophrenia—can be omitted from the assessment battery.

Psychological tests and inventories

There are numerous other standardized tests of cognitive, personality, and psychosocial functioning that traditionally are administered, scored, and interpreted by psychologists and that may be helpful in the mental health assessment of adults with a history of child abuse or neglect. For example, neuropsychological testing, intelligence testing, and objective and projective personality assessments can be useful components of a comprehensive psychological assessment. Such psychological assessments should be conducted or supervised by a licensed psychologist who is specifically trained to conduct, evaluate, and interpret these tools.

Trauma-oriented tools

Trauma-related assessments are important because they can help the treatment team understand the types of childhood traumatic events experienced by clients, their subjective response and perceptions of these events, and common current symptoms that may result from childhood trauma. A variety of trauma-oriented assessment tools have been developed to accomplish these tasks.

Trauma-oriented assessment tools include structured interviews and self-report instruments. The tools differ with regard to the types of information they elicit. For example, some structured interviews and self-report assessments evaluate trauma events, some evaluate trauma events and trauma symptoms, and some evaluate only trauma symptoms, such as dissociation. Some tools focus specifically on childhood trauma, such as child abuse and neglect. However, other tools examine a broad range of traumatic events. These tools may examine childhood trauma along with natural disasters and other types of trauma that might cause posttraumatic reactions. Most trauma-oriented tools described in this section are based on trauma-related clinical research and were developed for research, not for clinical or program-specific purposes. However, these tools can be used clinically.

Decisions regarding the types of instruments to use should be influenced by the purpose of the assessment, the setting of the assessment, the population being treated, and the individual client and the severity of his problems. For example, in a program that treats homeless veterans with substance abuse disorders, it would be important to include broad-based tools that evaluate the effects of exposure to combat as well as childhood trauma. In a program that targets suburban substance-abusing women, it would be more important to use tools that focus on childhood trauma. However, in a program that has a substantial group of single inner-city mothers who left abusive husbands, it would be important to use tools that can examine childhood and recent abuse experiences.

There is no standard trauma-oriented assessment tool, and no single tool can be considered truly comprehensive. Each has a slightly different purpose, with different strengths and weaknesses. Although extremely valuable, trauma-oriented assessment tools differ with regard to the groups on which they were normed (e.g., undergraduate students, male combat veterans, psychiatric clients). As a result, none of these tools should be considered the definitive answer to conducting trauma-oriented assessments. Rather, wisely selected, each of these tools can be a valuable component of a comprehensive assessment process.

Self-reports that evaluate histories of traumatic events

The following self-report tools are designed primarily to make assessments of histories of childhood traumatic events, such as physical, sexual, and emotional abuse.

Assessing Environments III, Form SD

This assessment consists of 170 items clustered into seven scales: physical punishment, sibling physical punishment, perception of discipline, sibling perception of discipline, sibling perception of punishment, deserving punishment, and sibling deserving punishment (Rausch and Knutson, 1991). An unusual feature of this tool is the inclusion of scales that elicit information about clients' perceptions and attributions regarding their maltreatment, an important feature since subjective evaluation of one's victimization can have an important impact on symptoms and treatment. Also, this assessment tool elicits the respondents' reports of the maltreatment of siblings, permitting a greater assessment of the family environment.

Childhood Maltreatment Questionnaire (CMQ)

This questionnaire assesses rejection, degradation, isolation, corruption, denial, emotional responsiveness, exploitation, verbal and physical terrorism, exposure to violence, unreliable and inconsistent care, controlling and stifling independence, and physical neglect. Although the focus of CMQ is on psychological abuse and neglect, it also assesses physical and sexual abuse (Demaré, 1993). CMQ elicits information about the frequency of maltreatment on or before the age of 17.

Trauma Assessment for Adults (TAA)—Self-Report

Like the structured interview form of TAA (see below), this brief 17-item tool assesses a wide range of potentially traumatic events. It evaluates the same set of issues and elicits the same basic information as the interview version of the instrument. It takes approximately 10 to 15 minutes, depending on the number of traumatic childhood experiences.

Traumatic Events Scale (TES)

TES evaluates a fairly wide range of both childhood and adult traumas (Elliott and Briere, 1992). Of the 30 specific traumas examined by this tool, one third focus on interpersonal and environmental childhood traumas. The interpersonal traumas assessed include physical, sexual, and psychological abuse, and exposure to spousal abuse. TES elicits details regarding the characteristics of child abuse, including age at first and last event, relationship to the abuser, and both past and current levels of distress about the abuse. TES also elicits significant detail regarding sexual abuse.

Self-reports that evaluate trauma symptoms

The following self-report tools are designed primarily to assess symptoms and syndromes related to childhood trauma, especially PTSD and dissociation. Some of these can be used to make a diagnosis of PTSD.

Dissociative Experiences Scale (DES)

This brief 28-item tool elicits information about the frequency of a wide range of pathological and normative dissociative experiences (Bernstein and Putnam, 1986; Bernstein et al., 1994). DES assesses dissociative amnesia, gaps in awareness, derealization, depersonalization, absorption, and imaginative involvement. It takes approximately 5 to 10 minutes to complete DES, and it has been the subject of substantial research efforts to evaluate reliability, validity, and utility.

Modified PTSD Symptom Scale: Self-Report Version (MPSS-SR)

Adapted from the PDS, MPSS-SR is a 17-item tool used to measure PTSD symptoms and make a tentative assessment about whether clients' symptoms meet DSM-IV criteria for PTSD (Falsetti et al., 1993). MPSS-SR yields scores for frequency and severity of PTSD symptoms and takes approximately 10 to 15 minutes to complete.

Penn Inventory for Posttraumatic Stress Disorder

This 26-item tool assesses most, but not all, DSM-IV symptoms for PTSD, as well as a few symptoms that are not directly related to DSM-IV criteria (Hammarberg, 1992, 1996). This tool asks clients to select one statement of four that best describes their feelings. The inventory takes approximately 5 to 15 minutes to complete.

Posttraumatic Stress Diagnostic Scale (PDS)

PDS is a 49-item tool that assesses all DSM-IV criteria for PTSD. It is designed to measure the severity of PTSD symptoms related to a single, identified traumatic event and to make a preliminary DSM-IV diagnosis for PTSD (Foa, 1996; Foa et al., 1997).

PDS includes a total severity score that primarily reflects symptom frequency. The tool provides a preliminary evaluation of DSM-IV PTSD diagnostic status, a symptom number count, a symptom severity rating, and a rating of the level of impairment of functioning. PDS takes approximately 10 to 15 minutes to complete.

Trauma Symptom Inventory (TSI)

TSI is a 100-item test designed to evaluate posttraumatic stress and other psychological consequences of traumatic events, including the effects of rape, spousal abuse, physical assault, combat, major accidents, natural disasters, and childhood abuse. TSI has 10 scales that measure the extent to which a client reports trauma-related symptoms. These scales evaluate anxious arousal, depression, anger/irritability, intrusive experiences, defensive avoidance, dissociation, sexual concerns, dysfunctional sexual behavior, impaired self-reference, and tension-reduction behavior (Briere, 1995, 1996). TSI includes 12 critical items that can help to identify potential problems that may require immediate attention, such as suicidal ideation or behavior, psychosis, and self-mutilation. It has three validity scales that can be useful in identifying response trends that invalidate test results. TSI requires approximately 20 minutes to complete.

Structured interviews that evaluate histories of child abuse and neglect

Some trauma-oriented assessment tools focus primarily on traumatic events, some focus on traumatic symptoms, and some evaluate both traumatic events and symptoms. The following structured interview tools are designed primarily to assess histories of child abuse and neglect. Some of these tools focus narrowly on maltreatment issues, while others examine childhood abuse and neglect within the context of a broad range of potentially traumatic events.

Child Maltreatment Interview Schedule (CMIS)

CMIS is a 46-item tool based on behavioral descriptions; it assesses emotional, physical, and sexual abuse. It evaluates five primary domains: (1) level of parental physical availability, (2) level of parental psychological availability, (3) parental disorder (e.g., history of psychiatric or substance abuse disorder treatment), (4) psychological, physical, emotional, sexual, or ritualistic abuse, and (5) perception of physical and sexual abuse status (Briere, 1992b). Within each domain, questions probe the age of onset, the relationship to the abuser, and the severity of the abuse. CMIS limits the assessment to events that occurred before age 17. A short version, CMIS-SF, contains most of the items of the original tool but with less detail (Briere, 1992b).

Childhood Trauma Interview (CTI)

CTI involves 49 screening items plus multiple followup probes for those items that are scored positive (Fink et al., 1995). CTI evaluates six categories of events: childhood separation and loss, physical neglect, emotional abuse or assault, physical abuse or assault, exposure to violence, and sexual abuse or assault. CTI takes approximately 30 to 90 minutes, depending on the number of childhood trauma experiences. It is useful for collecting detailed information about a wide range of childhood traumatic events and for quantifying the frequency, duration, and severity of these events. CTI involves queries about persons involved, the nature of the events, the age at time of events, the frequency of events, threats during events, the clients' speaking about the events, and the nature of injuries sustained (Carlson, 1997).

Evaluation of Lifetime Stressors (ELS)

ELS combines a 56-item self-report questionnaire with a semistructured interview to collect detailed information about potentially traumatic events (Krinsley, 1996; Krinsley et al., 1997). Positive responses to the self-report are followed up with more specific questions in the semistructured interview. ELS evaluates a wide range of potentially traumatic events. Nearly 30 different events are asked about, including accidents, illnesses, disasters, criminal violence, combat, and physical and sexual assault and abuse. This assessment includes questions about symptoms and experiences that suggest childhood trauma. The self-report questionnaire takes approximately 10 to 20 minutes to complete, while the followup interview can take 1 to 3 hours.

National Women's Study Event History (NWSEH)

NWSEH elicits detailed information about traumatic experiences and evaluates a range of potentially traumatic events, including rape, attempted sexual assault, molestation, physical assault, accidents, disasters, exposure to death or serious injury, and death of a friend or family member (Resnick, 1996a; Resnick et al., 1996). The NWSEH is used to evaluate thoroughly the first, most recent, and worst rape experiences; a single molestation; attempted sexual assault; and physical assault experience. The tool asks about the client's age at the time of the event, familiarity with assailant, relationship to assailant, fear of injury, actual injury, substance abuse by assailant, and whether the incident was reported. The tool contains 17 screening items with probes for positive answers to screening questions. Depending on the number of positive screening items, the test takes approximately 15 to 30 minutes to conduct.

Trauma Assessment for Adults (TAA)

TAA is a 13-item tool that evaluates a range of potentially traumatic events, including accidents, combat, disasters, serious illness, physical and sexual assaults, assaults with weapons, exposure to death or serious injury, and death or murder of a family member (Resnick, 1996b; Resnick et al., 1996). TAA evaluates in detail childhood sexual assault, including threat, injury, and penetration.

For each positive response, the tool elicits information regarding age at first or only time, age at last time, and the perception that the client would be killed or injured.

A structured interview tool that evaluates both traumatic events and symptoms

The structured tool described below is designed to evaluate both events and symptoms.

Clinician-Administered Posttraumatic Stress Disorder Scale (CAPS)

CAPS is a 30-item structured interview that measures symptoms of PTSD and acute stress disorder related to up to three traumatic events; it can be used to make diagnoses for DSM-IV PTSD and acute stress disorder (Blake, 1994; Blake et al., 1995; Weathers and Litz, 1994). CAPS elicits information regarding all DSM-IV PTSD symptoms, improvements in symptoms since a previous CAPS administration, general response validity, and overall PTSD symptom severity. CAPS also obtains information regarding five associated symptoms: guilt over acts, survivor guilt, gaps in awareness, depersonalization, and derealization. Overall, CAPS is extremely detailed and thorough. It takes approximately 30 to 60 minutes to administer. There are two versions of the CAPS: the CAPS-DX elicits information to make a current or lifetime diagnosis of PTSD, and the CAPS-SX assesses symptoms over the past week.

Special Considerations And Recommendations

Screening and Assessment Protocols

It is important that treatment programs develop written protocols regarding screening and assessment of histories of childhood abuse and neglect. All staff members should be familiar with these protocols and have a good understanding of the policies and procedures. Assessment protocols should describe such issues as

- When screenings and assessments should be conducted
- Who conducts screenings and assessments
- What type of data gathering is conducted
- What type of collateral data is gathered and by whom, and what limitations are made by confidentiality regulations
- How information is synthesized
- The role of each team member
- What instruments are used
- Who interprets the assessment findings
- How screening and assessment findings are presented and discussed
- How screening and assessment findings are documented
- How screening and assessment findings are incorporated into treatment plans
- Supervision by licensed mental health providers
- Mandated reporting policy and procedures

Cost Concerns

To conduct trauma-oriented assessments in a treatment program, the treatment team will need the assistance of mental health professionals and consultants with specific expertise in assessing and treating adults with childhood abuse and trauma. This can be expensive, and many programs do not have the funds to hire individuals with this level of expertise. To help address these cost concerns, the Consensus Panel makes the following recommendations:

- **Train staff.** It is less expensive to have one or more staff members receive the appropriate training than to rely exclusively on outside consultants. Ongoing training and continuing education are also vital to retain members of a treatment team. Training helps build team morale and confidence in a field that experiences a high rate of turnover.

- **Prioritize assessments.** Although all clients should be screened for childhood trauma, staff can prioritize who receives comprehensive assessments. Clients who are not willing or able to participate in treatment related to childhood trauma might not require thorough assessments at that time.
- **Establish university relationships.** Program administrators can establish alliances with local universities, university faculty, and researchers to help screen, assess, train, and supervise. Contracts with universities can be less expensive than with consultant groups. Many universities have faculty with skills in this area who can supervise graduate students to assist staff in community-based programs.
- **Use volunteers.** Programs can consider developing a pool of volunteer mental health professionals that includes both practicing and retired clinicians. Programs should contact local mental health associations and professional societies, most of which provide pro bono work.
- **Obtain and use inexpensive screening and assessment tools.** There is a wide variety of screening and assessment tools. Some are expensive and proprietary, while others are available free or at low cost. Some are available through the Internet. Appendix D provides contact information for many such tools.
- **Establish community partnerships.** Programs should identify all relevant regional resources, such as local community mental health centers, mental health associations and societies, and CPS agency representatives, and seek to collaborate with them.
- **Explore alternative funding.** Programs can consider using funding streams that are not normally associated with substance abuse treatment to help pay for trauma-oriented assessments. These may include funding from mental health and child assistance agencies, the Justice Department's Office for Victims of Crime, and private community organizations.

Screening and Assessment Interpretation Concerns

Screening and assessment tools have many limitations. Prominent among them is a lack of standardization and adequate psychometric study of many measures (Briere, 1992b). Many instruments focus on only one or two types of trauma, such as physical or sexual abuse (Briere and Runtz, 1990b; Bryer et al., 1987). Similarly, the technical or psychometric characteristics of these tools (such as reliability and validity) can vary considerably. The concerns about reliability and validity are compounded when employing these measures with ethnically and racially diverse populations. Intrinsic characteristics of individuals' response to trauma—such as denial, minimization, and dissociation—can make it difficult to validate these tests, because it is often hard to validate the specific events. Given these limitations, the Consensus Panel recommends that treatment providers not overemphasize standardized tests.

Although certain assessment tools are described as comprehensive, it should be understood that no single tool is a truly comprehensive approach to conducting a screening or an assessment. Rather, standardized tests should be used as guidelines and as valuable tools to create a framework for conducting screenings and assessments. These tools should be used only in the context of comprehensive clinical assessments conducted by multidisciplinary treatment teams.

Priorities of Managed Care

With the current emphasis by managed care organizations on brief treatments, it may be difficult in that setting to obtain authorization to assess childhood abuse and neglect. Some prefer that clients be sober for a length of time before doing so. Treatment staff should be aware that such difficulties may occur so that they can develop strategies to justify the additional costs of these focused and specialized assessments and subsequent treatment. Usually a mental health professional will need to request the authorization. For a more detailed discussion on managed care, see Chapter 7 of this TIP, and TIP 27, *Comprehensive Case Management for Substance Abuse Treatment* (CSAT, 1998a). See also the recommendations under "Cost Concerns" above.

Counselor–Client Relationships

There are many potential barriers to successful screenings and assessments of childhood trauma. To reduce some of these barriers, the Consensus Panel recommends the following:

- **Be sensitive to cultural concerns.** Values about corporal punishment vary considerably among cultures. What is considered abusive in one culture may be acceptable behavior in another. Staff should not be biased against people from ethnic and cultural minorities when reporting incidents of suspected abuse; however, it does appear that such a bias exists. Ethnic and cultural minorities are more likely to be reported for child abuse and neglect than are White Americans, and in most regions of the country White Americans are less likely to be involved with CPS agencies (Buriel et al., 1979). Community surveys have found that child abuse occurs equally at all socioeconomic levels; however, reported cases show a disproportionate representation of children from lower socioeconomic strata. It is likely that treatment professionals are more apt to determine that abuse occurs in disadvantaged families because this is in accord with the stereotypes of where abuse occurs (Finkelhor, 1993).
- **Recognize potential language differences.** Language differences can impede clear communication. Both written and spoken language should be simple and easy to understand. Clients with low levels of literacy or for whom English is a second language should be assisted in understanding self-reports.
- **Become aware of gender issues.** Treatment staff should understand that clinicians are less likely to ask men about their childhood abuse and neglect histories and that men are less likely than women to talk about these histories. Much of the trauma-related research has focused on women, particularly regarding battering, spousal abuse, rape, and incest. As a result, most assessment instruments have been normed on women. Overall, there is a lack of gender-specific instruments.
- **Be nonjudgmental and sensitive.** Because most individuals who were abused or neglected during childhood were maltreated by authority figures, they may approach the assessment process with fear, distrust, and performance or evaluation concerns (Briere, 1997). Consequently, those who screen and assess for childhood abuse and trauma should try to provide a safe and nonjudgmental testing environment and to address the issue of childhood trauma in a gradual and sensitive manner (Armstrong, 1996; Courtois, 1995).

The resources listed in Appendix E provide information and expertise on issues related to childhood abuse and neglect.

3 Comprehensive Treatment for Adult Survivors of Child Abuse And Neglect

The high prevalence of histories of childhood abuse among individuals with substance abuse disorders, as well as their frequent need for mental health services, has important implications for treatment planning and implementation. Moreover, as mentioned in Chapter 1, clients with substance abuse disorders who were abused or neglected as children may be more prone to relapse than those without such histories. The Drug Abuse Treatment Outcome Study (DATOS) (Craddock et al., 1997) found that an important factor in predicting treatment success was the number of services received, such as case management, parenting education, and counseling for childhood abuse and posttraumatic stress disorder (PTSD). Clients receiving additional services such as these were statistically more likely to stay in recovery.

Some estimates suggest that up to two thirds of all those in substance abuse treatment report that they were physically, sexually, or emotionally abused during childhood (Swan, 1998), whereas as many as 80 percent of people referred to mental health services have histories of childhood abuse (Briere, 1992a; Briere and Woo, 1991; Briere and Zaidi, 1989). Because an abuse history and a diagnosis of PTSD increase the risk of relapse, it is advisable to address these issues at some point during the course of substance abuse treatment. Although many clients need to address substance abuse issues before they are able to receive and benefit from treatment for past trauma, some need attention to the trauma before they can achieve sobriety. For some, it is during sobriety when they begin to experience symptoms of PTSD (such as flashbacks and nightmares) or recall memories of long-forgotten or repressed experiences of past abuse. As these uncomfortable and sometimes debilitating symptoms and memories emerge, many individuals return to using substances in an attempt to suppress their problems and manage their emotional pain. For example, Department of Veterans Affairs facilities often require a minimum of 30 days of abstinence before veterans can receive treatment for PTSD. If abstinence can be achieved and maintained without directly dealing with traumatic issues, it should be encouraged because abstinence will likely better prepare clients to face issues related to past trauma. However, if clients mention traumatic issues or suffer from intrusive memories or other reactions related to the trauma, the counselor should be prepared to address them, initially from an educational perspective that offers clients reassurance.

Treatment Issues

Counselors would do well to become familiar with the many ways in which childhood abuse and neglect issues can manifest themselves during clients' treatment. At the same time, they must remain open and ready for any possibility, realizing that disclosure does not always happen as one might expect. All clients need to work at their own pace. This is especially true for those with a history of childhood abuse or neglect, for whom disclosure of the abuse may take years.

Issues Surrounding Disclosure

Clients may enter substance abuse treatment for any number of reasons, ranging from self-diagnosis to mandated treatment for those referred by the criminal justice system. Whatever the reason for entering treatment, it is not unusual for a client to first identify or disclose a history of childhood abuse when in treatment. Counselors should understand that identification and disclosure of an abuse history occur in a variety of ways and for a variety of reasons. As discussed in Chapter 2, it is recommended that all psychosocial assessments include questions about past abuse and trauma and that questions be asked in behavioral terms to increase clients' understanding (i.e., "Were you struck or beaten as a child? Were you physically hurt as a result of someone hitting or beating you? As a child, did you ever have a sexual experience with an adult or a relative?"). Such direct questioning often prompts disclosure of past abuse; however, some individuals with positive abuse histories do not disclose because of feelings of shame, mistrust, or fear, or because they downplay their experiences by labeling them as normal and deserved and therefore not abusive. Others disclose only when issues concerning the abuse of their own children are raised.

Acknowledging past abuse can be an important step for clients in treatment because it breaks the secrecy and shame that are so often part of the abuse legacy. Many clients may find it easier to "confide" their history to a computer screen or a piece of paper than to another person. For some clients, the act of acknowledging is so relieving that it is healing in and of itself. However, for most, acknowledgement alone is not enough and requires additional therapeutic work for full resolution of abuse-related issues.

Once abuse history has been disclosed, it is important that it be acknowledged and not dismissed by the counselor. Counselors should be aware that clients may be hypervigilant regarding counselors' reactions to their experiences. Clients may interpret seemingly insignificant behaviors as signs of blame or rejection and may need considerable reassurance from the counselor that she does not hold them responsible for the abuse or view them differently because she knows about it. Sometimes, clients will project personal discomfort about discussing the abuse onto the counselor and may need to hear that the counselor is willing and able to discuss abuse issues without becoming overwhelmed or rejecting the client.

Counselors should understand how to relate to clients sensitively and in a way that does not exacerbate long-standing emotional wounds. For example, as children, clients may have been punished, shut out, or sent away from the family when they attempted to tell someone of sexual abuse. If a counselor is too hasty in making a referral for childhood abuse issues after clients have confided their experiences, old feelings of rejection and abandonment can resurface, with the clients perceiving that they are once again being "sent away" for telling about the abuse. Even if there is no such suggestion, clients may become withdrawn after having been so vulnerable.

The counselor should be aware not only of this possibility but also that the clients themselves may not be consciously aware of or show any anxiety over these feelings.

Talking to a sympathetic listener can be an important first step for abused clients to begin the healing process. In the initial crisis that often arises from disclosure, the counselor's most important tasks are to reassure clients of the safety of the treatment environment and to actively teach techniques for safety and the safe expression of feelings in everyday life (see "Dealing With Disruptive or Dangerous Behavior" in Chapter 4). Additionally, the counselor may need to respond to any active crises. Some clients require medical supervision in inpatient or intensive outpatient programs (at least during the early stages of abstinence) as they deal with their intense feelings of rage, anxiety, depression, or their debilitating symptoms, including impulses to harm themselves or others. The treatment provider should make clear to clients that they now have the capacity to deal with traumatic memories and related destructive behaviors stemming from childhood abuse which they lacked as children.

The counselor can help clients by providing a structured environment in which they can assess their feelings on a daily basis. One way to do this is by helping them reflect each day on what their needs are for that day—for example, rest and exercise—and how well they are meeting and addressing those needs. Encouraging clients to write in journals can be a helpful technique. For example, writing about an anger episode in a personal journal can be useful for clients with rage issues (Potter-Efron and Potter-Efron, 1991). Describing incidents of anger can help these clients gain a degree of distance from their rage and evaluate the effectiveness of how they typically deal with anger.

Although the primary focus of the treatment will be on substance abuse, the counselor should incorporate issues related to abuse and neglect into the treatment as needed. In acknowledging clients' childhood abuse and neglect, the counselor must validate clients' experiences by recognizing the issue. In this process, clients are helped to remember more (if they desire) and express their feelings. They can come to recognize themselves as victims, rather than the cause of the abuse, alleviating the feelings of guilt and shame that abused children typically take upon themselves and carry into adulthood. Through empathic listening, the counselor can help clients develop internal control by acknowledging their histories of abuse in order to move on. For instance, the counselor can point out to clients that the mere act of walking into the counselor's office and the very fact that they function despite their histories of abuse are important signs of strength. The counselor must actively acknowledge these strengths. If nothing else, the counselor is effecting a positive intervention by creating an environment that allows this process to take place.

How or when abuse issues are incorporated will vary with the needs of the clients (as determined by the initial and ongoing assessments) and by the treatment model espoused by the treatment facility or individual counselor. As a preliminary step, the counselor can educate clients about the possible impact of abuse and neglect in general and as it pertains specifically to the substance abuse disorder. Such an educational approach can be immediately therapeutic because it can help clients understand and normalize responses and symptoms. Traumatized and substance-abusing individuals often believe that their symptoms mean that they are crazy or are going crazy. Learning that certain effects and symptoms are part of a predictable and normal course of reactions can be very relieving and in some cases can stimulate the recovery process.

Counselors can explain the treatment process itself and when it will be necessary to address abuse issues as part of treatment, which constitutes part of the informed consent process. Involving and informing clients of this process make them more invested in their own treatment. They can be invited to work collaboratively with the counselor about whether and when to address issues related to childhood abuse in their treatment for substance abuse. A collaborative stance engages clients in problemsolving and indicates that they have some control in the process. Such a stance has the effect of countering the lack of control that occurs with abuse and neglect and thus can also have a direct therapeutic benefit.

Last, the counselor has to be a consistent presence for clients and must respect the clients' confidentiality. Many clients who have been abused direct their feelings of anger and rebelliousness against any adult figure, including the counselor. The counselor must carefully pace the clients' treatment by monitoring anxiety and depression levels and by taking other cues directly from the clients.

The Use of Medications During Treatment

The anxiety and feelings of pain that might surface when a client becomes more aware of past abuse are often related to PTSD, and selected psychiatric medications may be required to help the client through this painful period. Because some clients may have self-medicated with substances does not mean that they have no legitimate need for medication. The use of medications as a specific treatment technique is a potentially troubling strategy for some alcohol and drug counselors; however, it is routinely assessed for use with abuse and trauma disorders because of the high co-morbidity of debilitating depression and anxiety. Obviously, this approach—as an aid to stabilizing clients for other therapeutic interventions—should be used only after careful assessment and with prescriptions written by a medical professional who is aware of addiction issues.

Sequential, Integrated, and Concurrent Treatment Approaches

Many programs use a *sequential* model of treatment, in which a period of abstinence is required before a client can move on to psychotherapeutic treatment of issues related to childhood abuse or neglect. Many treatment providers associated with programs of this sort believe that psychotherapeutic intervention for issues surrounding clients' abuse history cannot be effective until the client has maintained abstinence for some period. During the time that the client is achieving abstinence, the counselor can gather information about relevant psychological issues, including those related to a history of abuse and neglect, which can then be passed on to a mental health practitioner when formal psychotherapy is undertaken. An important exception, however, is in cases of ongoing violence either directed toward or perpetrated by the client. In recent years, as alcohol and drug counselors have recognized the significant overlap between the addiction and abuse populations and their treatment issues, many have come to believe that people who have suffered severe abuse and neglect as children may not be able to stop abusing substances until they deal with abuse issues early in the treatment process. Two treatment models of this sort are available—the integrated model and the concurrent model.

In the *integrated* model, which addresses dual diagnosis (i.e., substance abuse and mental health treatment), both substance abuse and childhood abuse or neglect are treated in the same program. The provider might also serve as a mental health counselor or address abuse issues from a psychoeducational perspective in conjunction with the substance abuse treatment.

A comprehensive dual diagnosis model of this sort (labeled "the dual recovery model") has been proposed (Evans and Sullivan, 1995).

In a *concurrent* treatment model, referrals are made as appropriate for needed mental health services while the substance abuse treatment continues. In this model, staff members who are not substance abuse treatment professionals may deliver mental health treatment. In any situation where clients are receiving services from different providers, all parties involved should work together to act in the best interests of the clients.

The Consensus Panel believes that each case must be evaluated separately. There will be cases in which clients need to address an underlying mental disorder before they are capable of maintaining abstinence, as well as times when an extended period of abstinence (from 6 months to a year) will be required before clients are ready to address past trauma. This issue continues to be a subject of debate, especially since third-party payors generally allow a limited number of visits for substance abuse treatment (Marlatt and Gordon, 1985). Regardless of how treatment is structured, a comprehensive assessment is needed first to determine what kind of treatment is most appropriate and to systematically address the needs of the individual client.

Timing of Therapeutic Interventions

The type of treatment that is most suitable to the individual can be determined in a number of ways. Although traditional 12-Step approaches emphasize a linear model of recovery in which abstinence takes priority over all other issues, research data are not yet available to indicate the superiority of this approach. Yet, even if the linear model is the superior one, a reasonable compromise is needed for issues of childhood abuse and neglect. The overlap between addiction and violence in families should be discussed throughout treatment, in conjunction with more customary discussions about dysfunctional families and family roles. Addressing multiple issues simultaneously rather than in a step-like manner may actually be indicated and potentially more effective for many people.

If an individual has active and acute trauma-specific (i.e., PTSD) symptoms, in most cases it is optimal to address them immediately so they do not interfere with the client's ability to establish and maintain abstinence. If an individual does not have acute or debilitating symptoms, he may be able to establish abstinence before addressing trauma-related concerns. If he fails to establish abstinence first, despite indications that a non–trauma-focused treatment seemed most appropriate initially, then that may indicate the need to address trauma issues first.

In addition, direct therapeutic intervention for childhood abuse and neglect issues will often have to be included at some point in treatment, although precisely when depends on the needs and status of the clients. The first stage of substance abuse treatment occurs during detoxification and the first 30 days afterward, the period in which clients are becoming engaged in treatment. In-depth attention to issues of childhood abuse and neglect is generally not appropriate during this stage. The second stage of recovery may last anywhere from 30 days to 2 years, during which clients are establishing new and "sober" relationships, securing employment, participating in support groups such as 12-Step programs, and possibly reconnecting with family. During this second stage, clients may feel a need to address childhood abuse and neglect issues but should not be expected to do so. The third stage is, in many ways, the rest of the clients' lives, during which they are recovering from their substance abuse disorders. In this stage, clients generally can better deal with a broader range of issues.

Although progress through these stages can differ substantially for each client, the primary focus of treatment can be expected to change eventually from substance abuse to other psychological issues such as those associated with childhood abuse and neglect. For some clients, this transition can occur relatively early in treatment; for many others, these issues will need to wait until sobriety has been achieved and they have spent some time working on issues surrounding their substance abuse.

Whatever the sequence and time, it can be very helpful to ask clients to identify the issues to be addressed and in which order, and to develop short- and long-term goals for doing so. Such a treatment plan would also address what steps clients need to take to implement the plan and the identification of potential relapse triggers. For clients who are not yet stable in their recovery or who cannot yet tolerate such exploration, developing such a plan helps maintain their focus on immediate recovery issues and establish some direction regarding when and how to address childhood abuse in the future. It also assists in redirecting clients who are insistent on working with abuse and trauma-related issues at the outset of treatment, before sobriety is achieved. The counselor should understand and empathize with the clients' sense of urgency. Clients may be desperately trying to get rid of profound emotional pain and debilitating symptoms. The counselor must be able to express an understanding of the clients' urgency while simultaneously encouraging them to "stay the course" and to "make haste slowly;" that is, address abuse and trauma issues at a pace that is tolerable and that does not lead to regression or relapse.

Clients may approach treatment with a great deal of mistrust and skepticism. They might start by asking the counselor such questions as, "Can you promise me that my life will be better if I stop using, or if I face my abuse and trauma issues?" In the short term, self-medication with substances may seem overwhelmingly preferable to a distant (and perhaps unimaginable) time when life will be better without them. Clients may think that the counselor wants to take away their primary means of coping, leaving them unable to function because of the severity of their emotional pain and symptoms. Therefore, the counselor must search for and apply any available leverage to help motivate clients for treatment while getting through the short-term pain until some treatment benefits can be realized. Clients must be engaged in a way that will give them hope and increase their beliefs in their own power to overcome and resolve abuse issues to create a new life.

Some clients may actually succeed in stopping their substance abuse without relapsing but without apparently ever confronting their childhood abuse issues. It should not be assumed that such clients have not dealt with those issues; in some cases they may simply have not done so openly. In other cases, these clients may not be ready to discuss issues of abuse and trauma. In still others, clients recoil from emerging memories of abuse and may need to recant (often several times over) and struggle with the possible reality of their memories before arriving at a point of acceptance. Such "resistance" functions as protection and often yields as clients become less vulnerable and more able to face and accept the situation. Clients should never be forced to confront these issues if they do not feel ready. Forcing clients to do so may recreate an abusive situation and retraumatize the client. It is also important for the counselor to accept that some clients may not require or desire intense focus on abuse issues in order to facilitate their substance abuse treatment. The determination of whether to address childhood abuse is often dependent upon the clients' symptoms and ability to stay sober and is ultimately the client's and not the counselor's choice.

It is noteworthy that this sequenced model of treatment is consistent with the contemporary treatment model for posttraumatic conditions (Courtois, 1999; Herman, 1992; van der Kolk et al., 1996). The model for posttrauma treatment is also sequenced and begins by focusing on the clients' personal safety and the stabilization of personal functioning and outstanding life stresses and difficulties (including dependency); developing the therapeutic relationship is also addressed. In the first phase of treatment, clients are encouraged to defer attention to the traumatic material in favor of personal safety and stabilization. If clients are actively suffering from posttraumatic symptoms (as well as other symptoms such as depression and anxiety), these are treated first with cognitive–behavioral strategies aimed at increasing self-management and with psychotropic medication as needed. Clients are also taught skills for identifying and expressing feelings and for modulating and coping with strong feelings. The traumatic event(s) and reactions are addressed only as they support clients' stabilization and from an educational perspective. Clients are given definitions for various terms (such as trauma and child abuse and neglect) and are taught about the human response to trauma to normalize posttraumatic reactions.

The second phase of treatment incorporates much more direct attention to trauma and its effects. Clients are taught to address the trauma without the use of negative coping methods (including substances and processes such as dissociation) but must also learn that exposure must be carefully monitored so that they are not overwhelmed and retraumatized. Facing traumatic material is usually the most difficult and painful part of the treatment, and clients often relapse to old coping methods. For this reason, they are actively engaged in relapse planning, including the identification of triggers and strategies to use when they feel overwhelmed. As the trauma is processed and resolved, clients gradually move into the work of the third phase, which focuses on life choices and on a life less encumbered by the effects of trauma. This phase may last long after the client completes treatment.

Interpersonal Issues

The counselor must be aware of personal and interpersonal developmental deficits (see "Challenges to Accurate Screening and Assessment" in Chapter 2) and must work to remediate these issues through skill development and through the counseling relationship.

Clients with a history of child abuse or neglect typically have feelings of abandonment and betrayal that often become funneled into rage. In addition, substance use that began at an early age—between 8 and 18 years, when children should be learning to develop intimacy and deal with their feelings—can result in arrested emotional development and an inability to deal with strong emotions while abstinent. Assisting these clients to develop life management skills begins with helping them to identify and understand the intensities of their feelings. It is the unfortunate legacy of childhood abuse that victims must learn to repress their emotions to survive. Victims tend to become vigilant to the emotional states of others at the expense of being aware of their own. In cases of repeated abuse, the victims become constantly alert to the abuser's every move and nuance in order to avoid sparking another abusive incident. That ability, which served them well in childhood, has now been carried over into adulthood and interferes with the ability to function with a full range of feelings.

For victims of abuse, problems in forming attachments are often paramount. The abuse has led to feelings of distrust, betrayal, and abandonment and has caused a disconnection from other human beings. Substance abuse only compounds this rift by creating a false sense of belonging. The process of reattaching—or attaching for the first time—to other individuals, to a community, or to a spiritual power may take a long time, but it does have great therapeutic value. This may involve an activity—such as taking a class in writing or painting, working with animals, or joining a 12-Step group or a church—that fosters feelings of belonging. Daily affirmations—the reflection on positive statements about oneself—may help foster spiritual growth. For clients, spirituality may be in the form of an organized religion or activity in which participation makes them whole, centered, and connected to some superior or overarching force (Whitfield, 1984).

Clients who grew up in an abusive household have learned survival skills that allowed them to function in an often hostile and unpredictable environment, one in which they needed to be hypersensitive to others' moods and behaviors. Fears of intimacy are likely to hinder them, and the counselor must respect these clients' boundaries and limitations. Clients' fears of intimacy will often manifest themselves in concern about losing control or being abandoned or attacked (Sheehan, 1994).

Counselors may need to explain to clients how the problems in their past can affect their relationships in the present and how proper skills training can help them to overcome these deficits. Counselors should reassure clients that these deficits are understandable in light of their history and should be prepared to help them develop needed interpersonal skills.

Helping clients develop interpersonal skills involves enabling them to interact empathetically with others, to understand and be understood, to be able to ask for what they need, to draw personal boundaries by saying no, and to cope with interpersonal conflict (Whitfield, 1993). Other skills highly useful for this population include anger management, learning how to recognize unhealthy relationships, assertiveness training, and conflict resolution. The development of such skills allows clients to establish and maintain interpersonal relationships while keeping their self-respect.

Because of the central role of interpersonal relationships in women's development, women with substance abuse disorders and histories of child abuse are particularly vulnerable to interpersonal stress—and responsive to interpersonally focused interventions. Because the support networks of these women are typically impoverished, interventions that provide an immediate support network as well as foster improvement in interpersonal skills are essential first steps in shoring up the women's social networks and bonds (Luthar and Suchman, 1999; Luthar and Suchman, in press).

One of the most important roles of the counselor is to model behaviors in healthy relationships. Many abuse survivors never learned this in childhood and have to learn the most basic skills. The counselor should make it a point to show up on time and have expectations for clients to do so as well; he should also always behave in a warm and respectful manner. By simply being there, the counselor models key aspects of a healthy relationship: consistency, respect, empathetic listening, trust, and setting clear boundaries.

Group therapy can be a good setting for interpersonal skills training, but because of the highly volatile and sensitive nature of childhood abuse and neglect, group therapy may not be appropriate for many clients dealing with these issues (see the "Group Therapy" section later in this chapter).

Treatment Techniques

Seminal writings about the therapist's contribution to the therapeutic interaction

(Rogers, 1959; Traux and Carkhuff, 1967) suggest that certain characteristics are essential for effective treatment across therapeutic modalities: (1) unconditional positive regard or nonpossessive warmth, (2) a nonjudgmental attitude or accurate empathy, and (3) sincerity. Although many would argue that these are not sufficient for positive outcomes, there is evidence that these characteristics are important to establishing a working alliance with the client. For example, research has shown that an empathic therapist style is associated with more positive long-term outcomes (Miller and Sovereign, 1989; Miller et al., 1980).

For effective treatment, clients must be motivated for change. A counselor may need to address motivation before change can occur. For the counselor, the pace of some clients may seem so slow that it appears the clients are avoiding the issue. Nevertheless, the counselor must respect the clients' boundaries regarding how much and when to talk about abuse or neglect. To force the issue or to confront clients about abuse would be to reenact the violating role of the perpetrator. In dealing with clients with histories of child abuse and neglect, the counselor must strike a delicate balance between allowing clients to talk about the abuse when they are ready and not appearing to maintain the conspiracy of silence that so often surrounds issues of child abuse.

The counselor also must be prepared for the possibility that clients may disclose their childhood abuse or neglect without being asked about it. Disclosure of past abuse or neglect sometimes happens spontaneously in counseling sessions, without any intentional elicitation from the counselor or preplanning on the part of clients. In some cases, clients believe that the sooner they address the abuse, the sooner they can resolve it. Exposure to the issue in the media may have led others to believe that this is typical, that is, "what they are supposed to do." Still others feel a sense of urgency because they know they are allowed only a limited period of treatment. They may attempt to pressure treatment providers into addressing abuse issues prematurely—before they have adequate coping skills to manage the potential effects of such exploration. However, counselors must maintain appropriate pacing and teach clients to develop skills in self-soothing techniques so they can manage uncomfortable or volatile feelings.

When working with adult survivors of childhood abuse, the counselor can help clients situate the abuse in the past, where it belongs, while keeping the memory of it available to work with in therapy. Emphasizing a distinction between the emotions of the client as child victim and the choices available to the adult client can help this process. Recognizing this separation, clients can learn to tolerate memories of the abuse while accepting that at least some of its sequelae will probably remain.

Regardless of how or when clients talk about their abuse histories, the counselor must handle such disclosures with tact and sensitivity. Children who have been abused, especially at a young age by parents or other caretakers, will usually find it difficult to trust adults. When children's first and most fundamental relationship—that between themselves and one or both parents—has been betrayed by physical, emotional, or sexual abuse, they are likely to grow up feeling mistrustful of others and hypervigilant about the possibility of repeated betrayals. This vigilance is, in many ways, a resilient strength for children, who lack many of the protective resources of adults. As adults, however, it often stands in the way of forming intimate and trusting relationships. The counselor must take care not to tear down this defense prematurely, because to do so may result in discrediting or invalidating the experience of the abuse and in some cases may be perceived as abusive in itself. Patience and consistency help to reassure clients of the counselor's trustworthiness. Counselors should not assume that they have the clients' confidence simply because a disclosure has been made; with victims of childhood abuse, trust is often gained in small increments over time.

When the treatment does focus on issues of past abuse, the Consensus Panel recommends that the counselor support clients for what they can recall while reassuring them that it is quite normal to have uncertainties or not to remember all of what happened in the past. More important than the accuracy of the memory is the emotional reaction to, and consequences of, the experience; memories over time may be distorted, especially when remembered through the eyes of a child, but the feelings they engender are the most significant aspect of the experience. This last point is especially important because many survivors fear that if they disclose their histories, whomever they tell will deny that it happened. Even if the counselor finds clients' accounts difficult to believe, he can look for and respond to the emotional truth of it.

Moreover, the counselor should remember that until some degree of abstinence is achieved, clients' perceptions of reality are likely to be limited and their judgment poor. When clients disclose histories of past abuse before abstinence has been achieved, the counselor should note the information on childhood abuse and neglect, realizing that it will be important to explore this matter more thoroughly when clients have achieved a period of abstinence. When the topic is revisited later, the counselor should explain what parts of the story are the same and what parts differ, because this information may be therapeutically important. It is not unusual for trauma survivors to remember more with the retelling of their stories; however, the counselor should make note of major inconsistencies in order to discuss them with clients over the course of treatment. For example, the abuse may have been perpetrated by someone other than the person whom the client first remembered. Information such as this can have an extremely important bearing on family counseling, as well as other aspects of treatment.

Working From a Position of Supportive Neutrality

Counseling techniques for treating substance abuse in clients with a history of child abuse or neglect include interviewing from a stance of supportive neutrality. By asking, for example, what clients believe was both good and bad about the substance abuse, the counselor explores clients' perspectives and elicits rather than conveys information. The counselor's goal should be to motivate clients to explore their own issues and determine for themselves how the history of abuse relates to their substance abuse. Clients' motivations—for dealing with either abuse or substance abuse—will waver, but that is part of the process. (For more information on motivational techniques, see TIP 35, *Enhancing Motivation for Change in Substance Abuse Treatment* [CSAT, 1999c].)

Group Therapy

Although group treatment, including 12-Step programs and group therapy, is generally the treatment of choice for individuals who abuse substances (Barker and Whitfield, 1991; Washton, 1997), some individuals with childhood abuse issues may not do well in group settings. They may either find themselves unable to function or else try to undermine the group process to protect themselves from painful issues they would rather not face. This kind of behavior may point to hidden issues that the counselor should explore further. If childhood abuse issues surface during a group session (as they often do), they should not be ignored, nor should clients be discouraged from talking about such issues. However, trauma itself should not be the focus of treatment for a substance abuse disorder.

The length, intensity, and type of treatment may need to be altered for clients if childhood abuse or neglect issues surface during treatment. If possible, clients with these issues should be given the chance to participate in groups that focus on the specific issue of adult survivors. Trauma-related groups are not generally recommended during the early stages of treatment for a substance abuse disorder, when clients are still trying to achieve abstinence; however, groups that are designed to teach and educate clients about trauma and substance abuse can, at times, be quite helpful. (Exceptions can be made, however, for clients who continue to relapse during this early stage of treatment.) Survivors of childhood abuse should participate in a trauma-focused group only after clients' "safety and self-care are securely established, their symptoms are under reasonable control, their social supports are reliable, and their life circumstances permit engagement in a demanding endeavor" (Herman, 1992, p. 224).

In some cases, the first clue about the possibility of childhood abuse may be that a client is constantly undermining the group process, or the client may simply withdraw, becoming silent or dropping out of the group. Group therapy can be done effectively with this population, but counselors should keep in mind the population and the issues being dealt with and adjust goals accordingly. The group process can be an excellent way to help these individuals begin to address their attachment issues and—in a safe, controlled environment—practice disclosure and providing support to others. Adult survivors who are severely dissociative may have a hard time in any group setting. It is important that these clients are offered a symptom management program in which they can learn to use coping mechanisms other than dissociation. Clients with dissociative disorders may be very suggestible and easily disturbed by peer discussion of stressful experiences. This is not only a problem for the survivor in question but can also be disruptive and distressing to the group.

The appropriateness of group therapy for substance abuse treatment should be assessed for each client. As a general rule, though, groups that provide education, support, and counseling about substance abuse, trauma, and posttraumatic reactions are preferable in the early stages of treatment to groups that try to provide more in-depth therapy. For example, intensive group psychotherapy is generally not beneficial for new clients in the primary stages of treatment, which should focus on more general substance abuse issues (Barker and Whitfield, 1991).

Gender-specific groups for survivors of sexual abuse

Clinical experience indicates that groups structured specifically for women or men are more beneficial, especially during the early stages of substance abuse treatment. After clients have become more stabilized and can better empathize and share with others, mixed-gender groups may be more appropriate and can offer special opportunities for individuals to work through their issues differently. Some clients, however, may never be comfortable in mixed groups, and this should not necessarily be viewed as a measure of progress. Gender-specific groups are equally beneficial for abuse survivors in treatment, particularly if the abuse issues are identified early.

Research shows that women especially tend to do better in groups specific to women (Lerner, 1988; Wald et al., 1995; Wedenoja and Reed, 1982), although men may benefit from male-only groups as well (Briere, 1989; Catherall and Shelton, 1996; Corey and Corey, 1996; Harrison and Morris, 1996; Krugman, 1998). It is also helpful for sexual minorities (e.g., gay, lesbian, transgendered) to have their own groups when possible. Women who have been victims of sexual abuse perpetrated by men may find it more difficult to discuss that abuse with men present. However, in gender-specific groups women may be more willing to discuss their abuse than men. All-male groups may need more assistance from the counselor to begin discussing this topic.

Women and men have different conflicts and issues when dealing with their abuse experiences, but both might be affected by traditional societal views of gender roles. The difficulty that many men face in acknowledging past abuse is sometimes compounded by the conflict between perceiving themselves as victims and society's traditional expectations of men as powerful and aggressive. Male homophobia can also make discussions of sexual abuse, which often involve same-sex assaults, less likely to occur. Men may need help to form a view of themselves that neither exacerbates their feelings of victimization nor imposes unrealistic expectations of unwavering strength. Similarly, traditional societal views of women reinforce stereotypes of female helplessness. Whatever the gender stereotype, both men and women can often benefit from assertiveness training and learning to form healthy self-images that are not based on notions of fear and powerlessness. Some men may find it more difficult to work on these issues, or may be in denial, because of the social stigma around male weakness.

Whether treating individuals with abuse histories in mixed or gender-specific groups, it is important for counselors to avoid having preconceived notions about abusive events. Females may be more often the victims of sexual molestation by males, but sexual abuse is also perpetrated on males by both sexes and on females by other females. Given common expectations, it is especially important not to belittle men's experiences because many men have difficulty expressing uncomfortable emotions associated with abuse. For example, men who were sexually abused as children by females often have significant issues of shame surrounding the abuse (Krugman, 1998). In other cases, the enormous social taboo surrounding the sexual abuse of a son by his father can lead the survivor to feel that he somehow invited the abuse or to question his sexual orientation. Another common scenario is that of men who had distant and unavailable fathers and were abused at young ages (such as 12 or 13) by older men who sensed their neediness for a male connection during puberty (Catherall and Shelton, 1996; Harrison and Morris, 1996; Krugman, 1998).

The unfortunate truth of child abuse is that any scenario is possible. Both men and women are equally susceptible to the emotional damage that results from the profound betrayal of their trust in the adults who were supposed to take care of them. It is incumbent upon all treatment professionals, therefore, to bring to their work with these individuals sufficient knowledge, sensitivity, and understanding of the unique issues surrounding childhood abuse and neglect.

Self-help groups

Many alcohol and drug counselors are committed to the 12-Step model; however, that model can be problematic for clients with childhood abuse and neglect. Many survivors believe they do not have any control or power. Therefore, a 12-Step approach that asks them to accept their powerlessness might be more harmful than beneficial. The importance given to "surrender to a higher power" can also terrify or anger abuse survivors. They have had personal and very dangerous experiences with submission to human power and have often lost hope in higher spiritual powers that did not protect them in the past. Counselors must be sensitive to and respectful of survivors' needs to avoid this terminology. Twelve-Step organizations that work with this population (e.g., Survivors of Incest Anonymous) have reworded this step to make it less problematic for this population. In general, self-help groups can be tremendous sources of help for clients with all types of associated problems.

Involvement of the Family In Treatment

When adult survivors of child abuse enter treatment, clients' families may have a significant effect on the way in which treatment progresses. Every family has a unique style or unspoken set of rules that is used to maintain equilibrium in the family system (Satir and Baldwin, 1983). That equilibrium is thrown off balance by changes occurring with any family member. If one part of the family value or belief system changes, all parts of the system change—which may be threatening to some family members. When an outsider, such as the alcohol and drug counselor, tries to work with the problems presented by the client, the tendency in some families is to close ranks and come together to maintain a sense of equilibrium. The dynamics within abusive families may remain secretive, coercive, and manipulative, even if the actual abuse is no longer happening. Often the resistance of families is a way to protect and avoid disclosure, and abusers may still hold a strongly controlling position, even over their young-adult and adult children.

When family members oppose change, it often becomes evident during the course of treatment. The family may minimize the importance of the problem and not support the client's counseling. This is particularly true in families where substance abuse and child abuse are present; the family may be isolated from larger society and be fearful or angry about the counselor's interventions. In some cases, abusive situations may be currently taking place in the family. It is important to note that other family members may not know or want to know about the abuse of another member, whether ongoing or in the past. The counselor should understand that the resistance being encountered is taking place to preserve the family in the only way available to it. Of course, many families welcome change and want their family member to be abstinent; too often the family may be viewed as a potential problem when in fact it could be a great asset. The counselor should talk frankly with the family about the fact that change will be uncomfortable and stressful.

When family therapy is agreed on as a useful component of substance abuse treatment, it should only be conducted by a licensed mental health professional with specific training in the area of child abuse and neglect.

Confronting the history of abuse

When clients' families become involved in treatment, a decision must be made whether and to what degree the subject of abuse will be discussed. This decision is best made between the client and the counselor outside of family sessions (deciding whether to disclose to anyone outside the therapy relationship is strictly up to the survivor; mandated reporting laws, discussed in Chapter 6, would be an exception to this). In dealing with clients' current nuclear families, the counselor should explore with clients the possibility of discussing the past abuse within the context of how it affects the clients' substance abuse and current functioning within the family. In any first-time disclosure of abuse, the counselor must take care not to pressure clients to talk about the abuse with their families before they are ready. For the counselor to do so would be to reenact the role of the perpetrator.

Enlisting family members to support a client's treatment may have a positive impact on recovery. In some cases (e.g., when the perpetrator of the abuse is still present in the family), a team review should take place to decide whether to include the family. The team must take into account the client's comfort level and readiness for involving family, as well as her progress thus far in treatment for both substance abuse and mental health issues and any mandatory reporting guidelines that might apply. Counselors should be very cautious about discussing child abuse issues with family members while the client is still in treatment for substance abuse. Such confrontation may not be considered therapeutic or essential for every client.

Obviously, it is a delicate matter to discuss past abuse in the presence of family members who participated in or were present during it. When such a decision is made, the counselor must bear in mind that *he does not, and should not, have the role of confronting the perpetrator*. The counselor must avoid taking on the role of rescuer or defender of clients (see Chapter 4). For the counselor to insert himself into the perpetrator–victim system is to put an end to his therapeutic effectiveness. Nor is the purpose of enlisting family in treatment to allow clients to confront the perpetrator. As in individual sessions with clients alone, the focus must remain on supporting the client's recovery.

A number of problems are associated with accusing family members of abuse of their adult children. One risk is that the accusation will be denied, or the client will be blamed for the abuse, provoking intense emotions and possible relapse. Another problem is political and legal; there has been a strong reaction to accusations of childhood abuse by adults molested as children. Counselors have been accused and sometimes sued for implanting false memories as well as subjecting family members to unexpected accusations when they thought they were going into family therapy in support of their recovering son, daughter, or sibling. This is an unfortunate turn of events for counselors who believe clients and see dealing with these issues as important for recovery. In many cases, mediation is an effective option, but it is not possible with some families.

Deciding whether to involve the family

In most cases, open negotiations with an adult client's family of origin about past abuse should probably not happen until very late in individual therapy, if ever. (For a child or adolescent the situation and issues are quite different, of course.) Substance-dependent clients who have been abused are doubly vulnerable to further hostility and rejection from their families and may respond with either massive anxiety or relapse or both. Involving supportive family members might help with particular issues; for example, a domestic partner can be included in sessions on sexual or emotional intimacy problems.

In general, abused substance-abusing clients benefit most by a strong primary alliance with the therapist and not too much dilution with other relationships. This undivided support and allegiance in a relationship is, after all, what was usually lacking for the clients and what is needed to rebuild the self. Intensive individual therapy is usually the best approach for this type of client. The intended benefits of family therapy are often not worth the potential risks to clients in this unpredictable and emotionally charged situation. Furthermore, it must be emphasized that counselors should take a team approach whenever feasible and not take on more than is appropriate for their level of training, experience, and abilities.

The determination of whether family therapy is effective and appropriate for clients with histories of abuse or neglect depends on a number of factors. Among the most important is whether the history of abuse is known and acknowledged by the family. Other important considerations are clients' feelings and preferences and their current relationships with various members of their families. In evaluating the need for family therapy, providers must also consider clients' personal definitions of family, which may not fit expected norms. Regardless of biological relationships, the issue at hand is to identify the people who are nonthreatening and important in clients' daily functioning.

Before involving clients' families in treatment, the counselor must evaluate clients' tolerance level for the highly charged emotional material that is likely to ensue from taking this step. Ultimately, this decision should be made by the entire treatment team, including a mental health professional. However, family involvement is often therapeutic for the client and may be a predictor of successful recovery.

Respect for Cultural Norms

The counselor is in the delicate position of trying to gain the cooperation of families and engage clients in a way that does not threaten the family balance. A lack of understanding of clients' culture and specifically the family norms of that culture may hinder this process. In some cultures, someone outside the family may be viewed with distrust and her assistance is considered as interference. Or, in some cultures, calling the father by his first name may violate his authority and alienate him from the treatment process. Being aware of cultural norms that can influence the situation helps the counselor better understand clients and create a framework in which effective therapy can take place.

There is now an influx of immigrant populations to the United States from all over the world, and many come to this country because they have been displaced by war or other traumatic events. It is not possible for a counselor to be aware of all the issues faced by clients. Therefore, it is helpful for the counselor to ask clients and their families to teach him what he needs to know about the values of their culture. Admitting a lack of knowledge and asking specific questions demonstrate respect and are ways in which family members can participate in the treatment process. Families are often willing to discuss these issues, and the counselor gains the information needed to work with the client while building trust.

The Importance of Referrals

Counselors must be careful not to attempt too much when working with clients with a history of severe abuse. Although the best situation is one in which substance abuse and other mental health issues can be treated together in the same program, programs do not always have the resources to do so. When an assessment of symptoms indicates mental health problems that are beyond the scope of the counselor's ability to treat, a referral is clearly warranted. Suicidality, self-mutilation, extreme dissociative reactions, and major depression should be treated by a mental health professional, although that treatment may be concurrent with substance abuse treatment. The need for a referral, however, is not always so clear.

The treatment provider's first goal for clients is generally to help them stop using substances and maintain abstinence. Clients may wonder or inquire why they are being asked about their childhood in a program for substance abuse and dependence. For the therapeutic process to be effective, both counselors and clients may need to reach a deeper understanding of how the past contributes to present problems. Although the counselor is primarily concerned with substance abuse, she is often in the crucial position to identify clients' other needs, which if not addressed might lead to relapse or escalation of substance use.

The desired outcomes of referral for counseling about childhood abuse issues include the expectation that the referral is actually acted on, but referrals can only be made (and followed up on) with the client's permission. The treatment provider should follow through on the referral process to ensure that it is completed. Once a referral has been made, the mental health provider can help elicit further information about the client's history of child abuse or neglect. For clients with more severe mental health problems, the treatment provider's primary concern should be to ensure clients' safety and help minimize the risk of suicidality and relapse.

Mental Health Treatment Services

Treatment planning for clients with childhood abuse should be a dynamic process that can change as new information is uncovered, taking into account where clients are in the treatment process when the history of abuse is disclosed. What is known by both counselor and clients at the beginning of treatment is often different from what is learned later, as clients' capacity for coherence and clear thinking improves. Clients newly admitted to treatment who have not yet achieved abstinence are not likely to think clearly, to process or synthesize information, or to engage in meaningful self-reflection. Confronting abuse issues at such an early point in treatment may lead to escalation of substance use.

The counselor should prepare clients for mental health treatment by helping them realize (1) that their history of child abuse or neglect may have contributed to some of their errors in thinking and decisionmaking, (2) that they may have medicated themselves with substances in order not to deal with their feelings, (3) that they are not alone and resources are available to help them, and (4) they can learn better ways to cope and live a happier life. Regardless of when abuse issues arise in treatment, the counselor should gather information from clients to identify the referral sources that will be most appropriate and helpful. This information helps treatment staff as well, because past abuse may influence a person's chances of recovery and progress through treatment.

Decisions of when and where to refer will vary depending on the availability of local services. When those services are limited or nonexistent, treatment providers may have to be creative. Asking clients about possible sources of support—such as those they may have turned to in the past when this issue arose—may turn up resources such as clergy, teachers, or others in the community.

Case Management and Service Coordination

Case management and coordination of services are key to the provision of integrated or concurrent treatment and of appropriate referrals, especially in the case of referrals for childhood abuse and neglect issues. Once made, such referrals do not mark the end of substance abuse treatment. On the contrary, treatment for substance abuse disorders remains integral in the case management process.

Linkages between treatment providers and mental health agencies are crucial if the two programs are to understand each other's activities. In the interest of the clients, a case summary should be developed that lists the key issues that need to be addressed in other settings. (See Appendix B for information on getting the client's consent before making referrals or sharing information.) This not only helps clients but also enhances professional relationships between parties. Ideally, a case manager will coordinate all these services, but often the counselor serves as the coordinator. For more information on the importance of case management services in substance abuse treatment, see TIP 27, *Comprehensive Case Management for Substance Abuse Treatment* (CSAT, 1998a).

The reality of third-party payor systems is that substance abuse treatment is limited to a finite number of visits. Documentation of child abuse or neglect issues and their effect on the treatment process helps to delineate specific treatment intervention needs and allows for more effective treatment planning. Demonstrating the existence of childhood abuse or neglect and its impact on current dysfunctional behaviors early in treatment supports the complexity of the diagnosis and treatment planning process, thus helping to substantiate the need for greater support to third party payors. Counselors will often need to substantiate the complexity of a case so that they can begin to formulate a treatment plan. It helps to describe specific behaviors rather than using labels such as "substance abuse" or "childhood abuse and neglect," which will allow for behaviorally based interventions. A mental health assessment can provide a diagnosis that will be more acceptable for third-party payors.

Working with at-risk clients in today's litigious climate requires that counselors adhere closely to accepted standards and ethics of practice as well as the legal requirements of their position. Working within a multidisciplinary team with adequate supervision ensures that the counselor maintains such standards of care. Team members or colleagues in other agencies can be consulted about treatment issues as well as legal matters concerning reporting requirements and confidentiality.

Recordkeeping

Clients' treatment records are important documents. They provide historical overviews of each client's current status, past experiences, treatment goals, and subsequent progress. Counselors need to record this information in an organized, respectful, and sensitive manner, with the knowledge that others may have access to clients' records. It is best to find a balance in the level of detail recorded. Counselors should make it a practice to document only the factual, observable behavior of clients, and to record statements made by clients and not make judgmental statements about them. It is important to build an efficient means of recordkeeping that follows both Federal and State guidelines.

Instances of abuse and neglect that have been revealed must be recorded. To protect the provider, the record should state that the client reported abuse, rather than that the client was abused. When counselors do not record the information they are given, they lose the opportunity of transmitting needed information to future counselors. The message to the client must be that the information is important and needs to be recorded. If not recorded, the counselor is furthering a message of shame and secrecy. Often the information on past trauma or abuse is essential for developing a treatment plan and thus can help strengthen subsequent treatment. The case summary should document such things as clients' status at intake, the diagnosis, course of treatment (including any prescribed medications), status at discharge, the goals met while in treatment, the reason for discharge, and any referrals made. Records should also indicate the extent to which the original goals of the treatment plan were reached. Sufficient notes should be kept for this purpose because the outcome of treatment has important implications for accreditation and funding. Of course, sharing information in the record is bound by the rules of confidentiality (see Chapter 6 and Appendix B.)

4 Therapeutic Issues for Counselors

Alcohol and drug counselors, along with other mental health professionals, face a number of challenges and special issues when working with people who have suffered abuse or neglect as children. Like most people, counselors become upset or angry when they hear about children getting hurt or being abused. Some counselors are recovering from substance abuse disorders and were themselves abused or neglected as children, and they may find themselves in a professional situation where they have to confront their own abuse experience and its impact on their lives. As a consequence, counselors who were abused or who had substance-abusing parents may experience feelings that interfere with their efforts to work effectively with adult survivors. For example, counselors may find it difficult to relate to clients effectively and to reach a balance of providing enough—but not too much—support and distance.

Survivors of abuse may pose many relational challenges to the counselor. These clients are often mistrustful at the same time that they need a trustworthy relationship, and a "push-pull" dynamic may result. Counselors may find themselves overly fascinated by and invested in a client's abuse history (sometimes to the exclusion of other life and therapy issues), or they may want to avoid discussion of the abuse for personal reasons. Counselors must be mindful of these possible reactions and develop appropriate strategies to ensure effective care of the client. Because child abuse and neglect reflect the ultimate violation of trust, it is critical that counselors maintain a professional relationship with appropriate boundaries and limitations in place. The counselor must be trustworthy and provide a safe relational context that—in contrast to the client's past experience—presents a unique opportunity for healing.

This chapter reviews some of the challenges posed by transference and countertransference issues with this treatment population and discusses possible secondary traumatization in counselors. The Consensus Panel recommends that counselors establish and maintain clear boundaries from the outset, as well as establishing a "treatment frame." Some of the topics discussed below are basic to good counseling and clinical practice, but it is helpful to review them in the context of treating clients with histories of child abuse or neglect.

Transference, Countertransference, And Secondary Traumatization

The counselor–client relationship is a crucial component of all therapy. Its importance is highlighted in work with abuse survivors because of the nature of the injury caused by the abuse—it was often caused by someone in close relationship to the client, on whom she was dependent, and from whom she should have received care and protection. The counseling relationship is therefore instrumental in providing the client with the necessary support to address and work through issues related to abuse (including substance abuse) while modeling a healthy, nonexploitive relationship.

Transference

Transference generally refers to feelings and issues from the past that clients transfer or project onto the counselor in the current relationship. When clients interact with other persons, they are likely to respond in ways that repeat old patterns from their past. Clients bring the everyday responses and distortions of life into the relationship with the counselor, who, as a professional, can recognize these problems that are interfering with clients' daily functioning (Kahn, 1991). These transference reactions have specific implications for survivors of childhood abuse, who may perceive the counselor as threatening or abandoning in the same way as the perpetrator of the abuse. Conversely, clients may idealize the counselor, seeing him as the warm and loving parent they always wanted.

Clients' feelings about themselves might also affect the relationship. Many survivors have enormous shame and low self-esteem and feel responsible and guilt-ridden about the abuse. This may lead to attempts to distract the counselor from abuse-related issues so that they are not discussed or examined, or to respond to the counselor in ways that replicate the past (e.g., as caretaker, as self-sufficient and not expecting or deserving supportive attention). The counselor must be aware of and prepared for possible responses of this sort and must work to bring them to clients' attention for discussion. The counselor must also avoid replicating relational patterns from the past even if clients expect them and act in ways to encourage them. For example, the counselor should not allow clients to be overly caretaking toward him, nor should he be so overinvolved with clients that objectivity is lost. These issues are discussed in more detail below in the section "Establishing the Treatment Frame and Special Issues."

Countertransference

Countertransference refers to the range of reactions and responses that the counselor has toward clients (including the clients' transference reactions) based on the counselor's own background and personal issues. Although countertransference occurs in all therapy and can be a useful tool, an unhealthy countertransference occurs when the counselor projects onto clients her own unresolved feelings or issues that may be stirred up in the course of working with the client. If the counselor's own boundaries are not firm, she is more likely to have difficulty remaining objective and may respond to a client's transference reaction with countertransference. This is not the same thing as the counselor's subjective feelings toward the client, which may be positive (if the client is a friendly and attractive person) or negative (if the client has an unpleasant appearance and temperament). For example, if clients act seductively, the counselor may feel uncomfortable or threatened. Counselors must pay close attention to their own feelings to protect their clients and to learn more about them. At the same time, the counselor should keep in mind that the feelings clients evoke in a counselor are likely to be feelings that clients are evoking in their daily interactions with others.

Countertransference occurs when the counselor loses her objectivity and becomes overwhelmed, angry, or bereft when hearing a client's story. In such a situation, the counselor may push a client to deal with childhood abuse or neglect issues before the client is ready—out of the counselor's own emotional needs. For the same reason, a counselor might discourage the client from talking about abuse issues, saying it is not the right time. However, it is very important to let the client determine when and at what pace to work on the issues, especially when dealing with child abuse and neglect. Effective treatment will be severely diminished if the counselor is unaware of her countertransference feelings toward a client. In these cases, the counselor should be closely supervised, or the client may need to be referred to another counselor.

Counselors must also be cautious not to see signs of childhood abuse in every symptom. Because of the high incidence of childhood abuse and neglect among clients in substance abuse treatment and many counselors' earnest desire to help, there is a danger of overinterpreting nonspecific sequelae. Not everyone in treatment has been abused, and counselors should be aware of the possibility of clients recovering nonexistent repressed memories, especially from clients who are eager to please their counselor. (See also the section below, "Avoiding the 'Rescuer' Role.")

It is important for counselors to have a general awareness of these transference and countertransference issues and to be as knowledgeable as possible about their own areas of emotional vulnerability and unresolved emotional issues. This is especially important for counselors who are themselves survivors of childhood abuse or neglect.

Secondary Traumatization

Many counselors find the level of violence and cruelty they are exposed to in working with adult survivors of abuse upsetting and incomprehensible. The counselor who is repeatedly confronted by disclosures of victimization and exploitation, especially between parent and child, may experience symptoms of trauma, such as disturbing dreams, free-floating anxiety, or increased difficulties in personal relationships. He may also experience anger or helplessness, which are detrimental to both the counselor and the client. Or, after a day of dealing with intense material in client sessions, a counselor may seem unaffected until strong emotions emerge—seemingly out of nowhere. The stress and "burnout" that may result from working with such clients can even produce symptoms similar to those of posttraumatic stress disorder (PTSD) (e.g. anhedonia, restricted range of affect, diminished interest, irritability, difficulty concentrating, and insomnia). Counselors can have these reactions even if they have no personal history of childhood abuse.

Counselors experiencing these symptoms may lose perspective and become either over- or underinvested in a client (Briere, 1989; Pearlman and Saakvitne, 1995). Counselors who are underinvested may become numb to feelings that would otherwise cause anxiety, anger, or depression. A counselor may unintentionally, even unconsciously, dismiss, negate, or minimize a client's history of abuse. This reaction represents an attempt to avoid and distance oneself from the uncomfortable issues raised by the abuse. He may respond to the client coldly and clinically. Those counselors who overinvest, on the other hand, become extremely involved with their clients, going beyond the appropriate boundaries of the relationship. They may respond by becoming parental and doing problematic things such as lending their clients money, trying to solve their problems for them, or seeing them too frequently. They may also fail to confront clients when they behave inappropriately or destructively. When working with a client who was abused as a child, an overinvested counselor may have rescue fantasies or feel inappropriate anger directed at former therapists, child protective services (CPS) workers, and parents or caretakers. In extreme cases, the relationship can cease to be beneficial as it becomes overly personal, with the attendant loss of objectivity that is necessary in a professional relationship (Briere, 1989).

Burnout

As mentioned above, working with clients who have chronic mental health disorders, severe substance abuse disorders, or a history of childhood abuse and neglect can often lead to "burnout." Working with substance-abusing clients who have experienced childhood maltreatment can further challenge a counselor's capacity to remain focused in treatment. Burnout occurs when the pressures of work erode a counselor's spirit and outlook and begin to interfere with her personal life (De Bellis, 1997). These secondary trauma responses have been called "compassion fatigue" (Figley, 1995), referring to the toll that helping sometimes has on the helper.

Burnout affects many counselors and can shorten their effective professional life (Grosch and Olsen, 1994). If the counselor sees a large number of clients (many with trauma histories), does not get adequate support or supervision, does not closely monitor her reactions to clients, and does not maintain a healthy personal lifestyle, counseling work of this sort may put her at personal risk (Courtois, 1988). This situation is even more serious in the current financially focused managed care atmosphere that requires health care workers to assume larger and more complex caseloads. These complex cases often involve previously traumatized clients who present the counselor with many personal and treatment challenges (Grosch and Olsen, 1994).

Counselors can minimize the likelihood of burnout. As much as possible, they should not work in isolation and should seek to treat a caseload of individuals with a variety of problems, not only those who have experienced childhood trauma. Discussing feelings and issues with others who are working with similar clients can decrease isolation through a process of shared responsibility (Briere, 1989).

Counselors also should try to keep a manageable caseload. They should deliberately set aside time to rest and relax, keep personal and professional time as separate as possible, take regular vacations, develop and use a support network, and work with a supervisor who can offer support and guidance. Some treatment settings have established in-house support groups for counselors who work with abuse and trauma survivors. By sharing graphic descriptions of clients' experiences with a colleague, the counselor can gain the crucial support and perspective to be able to continue effective treatment. Working as part of a treatment team can be a natural way to facilitate support and reduce stress.

In some cases, counselors may want to seek personal help through therapy that will allow them to work more successfully with this population. Among its other potential benefits, psychotherapy can help counselors come to terms with their own limitations. Counselors who are satisfied with their personal and professional lives are less likely to experience secondary trauma symptoms.

Establishing the Treatment Frame and Special Issues

Counselors should develop and maintain a *treatment frame*—those conditions necessary to support a professional relationship. Setting and maintaining boundaries is especially critical in treating survivors of childhood abuse and neglect. Several parameters of the treatment frame are discussed below, as well as special issues that may arise. Because childhood abuse is a profound violation of personal boundaries, adult survivors of abuse or neglect may never have developed healthy and appropriate boundaries, either for themselves or in their expectations of others. They often need a great deal of affection and approval, and counselors must make clear that they are not responsible for directly meeting all of those needs. Boundaries help the counselor as well as the client because counselors tend to be nurturing healers, which may lead them to fall unwittingly into inappropriate roles in response to their clients' stories.

For example, a counselor may react to strong countertransference feelings by trying to respond to a client's wishes and expectations. The counselor should guide clients in doing difficult interpersonal tasks themselves, not only to strengthen the clients' ability to take responsibility for their lives but also to maintain important adult boundaries. The counselor must maintain a calm, optimistic interest in his clients, recognizing that getting overly involved will rob clients of the opportunity to identify and build upon their own inner resources.

Other parameters of the counseling relationship, or treatment frame, set by many mental health professionals (Briere, 1989) include

- Making regular appointment times, specified in advance
- Enforcing set starting and ending times for each session
- Declining to give out a home phone number or address
- Canceling sessions if the client arrives under the influence of alcohol or psychoactive drugs
- Not having contact outside the therapy session
- Having no sexual contact or interactions that could reasonably be interpreted as sexual
- Terminating counseling if threats are made or acts of violence are committed against the counselor
- Establishing and enforcing a clear policy in regard to payment

These are general guidelines, and the specific arrangements between a counselor and client will vary according to a number of circumstances. For example, a client may arrive under the influence of drugs or alcohol. Although the counselor will not conduct therapy, he should make sure the client doesn't leave the office and drive a motor vehicle. Also, for some clients, telephone contact outside the therapy session is necessary and fosters a working alliance between client and counselor. Some clients may need ongoing support for dealing with difficulties with their children or suicidal feelings. A rigid rule stating no contact outside of therapy may be harmful for very needy clients. Clients may feel abandoned if a telephone call is not returned, damaging the therapeutic alliance.

In smaller communities, a counselor may expect to encounter clients in public places. It is wise to discuss in advance with clients the confidentiality and boundary issues that could arise in these situations. Clients may prefer that the counselor not acknowledge them or may wish to be greeted with a simple hello. Addressing such issues in advance ensures that the client will understand the counselor's behaviors and will not feel ignored or abandoned.

Building Trust

Building trust has been described as the earliest developmental task and the foundation on which all others are built (Erikson, 1980). Establishing trust is broadly accepted as fundamental to the development of a therapeutic relationship. However, because adults who were abused or neglected by their parents have experienced betrayal in their most significant relationships, they often find it difficult to trust others. Clients who were not abused by persons close to them also experience problems with trust, but for those who have been betrayed by people on whom they were dependent, issues of confidentiality and privacy are especially critical. Trust makes an individual vulnerable to criticism, abandonment, and rejection. Clients may therefore be mistrustful and suspicious of the counselor, making the development of a trusting relationship a potentially long and difficult task. Reflecting the transference discussed above, they may fear the counselor or see him as abusive, manipulative, or rejecting. The counselor must not personalize these feelings but be consistent and reassuring, never taking trust for granted (Courtois, 1988).

As clients deal with childhood abuse and neglect issues, they may face a series of crises. These crises give the counselor opportunities to build trust. In such situations, the counselor can remain consistent and available, helping to allay clients' fear of abandonment and rejection. Many tenets of a good therapeutic relationship (unconditional positive regard, a nonjudgmental attitude, and sincerity) are also essential for establishing a foundation of trust.

When the Client "Falls in Love" With the Counselor

Because of the difficulties many abused clients have with intimacy, the new experience of having someone who listens and whom they can trust can sometimes lead them to believe that they are in love with the counselor. Sadly, many survivors of abuse are so accustomed to negative feelings (shame, fear, guilt, anger) that positive feelings (joy, trust, contentment, playfulness) are unfamiliar to them. Such clients may not understand their own feelings, and they may not have the skills to differentiate them. In some cases, if a client has recently stopped abusing drugs or alcohol, romantic obsession or sexual fantasies can substitute for the substance addiction as a way of reducing tension. Powerful romantic feelings may be directed toward the counselor, threatening the therapeutic relationship.

The counselor may first become aware that a client is having strong transference issues by subtle changes in the client's demeanor or by more obvious signs, such as requests to see the counselor in a nonprofessional setting. The counselor must, above all, avoid transgressing the boundaries of the relationship and continue to emphasize the guidelines discussed when the counselor established the treatment frame. He should not consent to personal requests, even if they seem innocent (e.g., having coffee or going shopping together). Second, even if he only suspects a client of harboring sexual feelings for him, he should immediately bring the matter to the attention of a colleague. This consultation will serve not only to protect himself, should legal complications arise later, but can also help him work through the difficulty in the therapeutic relationship itself.

If the counselor senses that a client is developing romantic feelings for her, she can try to discuss the matter openly by asking questions, such as "I sense that you are feeling very strongly about something today. Is there something in particular you want to talk about?" If a client eventually discloses romantic or sexual feelings, the counselor must maintain a therapeutic stance and uphold the boundaries of the client–counselor relationship. Clients should be encouraged to examine the feelings rather than act on them. The tension of this interaction can lead to a "teachable moment" in which the client learns to better differentiate his feelings. The counselor should remind the client repeatedly of the purpose of their sessions, emphasizing what she and the client will and will not do as part of the relationship. Clients often substitute an attraction to the counselor for an attraction to the abused substance as a way to avoid dealing with unresolved feelings or emptiness.

Another, less confrontational way to deal with this type of situation is to maintain the boundaries of the client–counselor relationship but to use clients' feelings to help them discover solid but non-sexual relationships with people who listen. The client can be assisted to differentiate feeling good from feeling sexual desire. The counselor can explain that the "attractive" aspects of their relationship, such as trust and feeling safe, are qualities that clients will want to look for in their personal relationships.

Similar problems of inappropriate attachments and boundary issues can occur in group therapy, and counselors (whether as group leaders or in separate individual counseling) must be prepared to work with their clients on this dynamic. Here, too, a treatment frame should be established at the outset that addresses interactions between group members and between the group leader and members. Clients should avoid letting any of these relationships become too personal and should be made to understand why, in this setting, developing sexual relationships would be counterproductive. Counselors, in turn, must understand and support the bonding that occurs when clients make disclosures in a safe and sympathetic environment—and the confusion group members may have about their feelings of dependence on or responsibility for other group members (Valentine and Smith, in press). These are therapeutic issues to be addressed in the group that can contribute to the clients' healing from the effects of abuse (Briere, 1989; Courtois, 1988).

The counselor's reaction to attempts at seduction

Because of low self-esteem, incest survivors (or other survivors of abuse) may feel that the only way they deserve a relationship with another person is if they offer sexual involvement (Courtois, 1988). If a victim of sexual abuse acts seductively toward the counselor, the counselor should understand that transference issues are in operation and that the victim is trying to sexualize the relationship. Unfortunately, some counselors do become sexually involved with their clients, thus exploiting the counseling relationship and violating the trust the client has placed in them. Such behavior is unethical, unprofessional, and in some States, illegal. Counselors who become sexually involved with clients may be reenacting the role of victimizing caretaker. Most treatment programs have policies prohibiting such behavior and will fire staff members who violate these policies. In addition, they are likely to register a complaint with the State licensing agency; professional associations will censure or expel members who have sexual contact with clients. In some States, sexual contact with clients is illegal, and counselors will be prosecuted.

Some in the treatment field believe that males should not treat female survivors of male sexual abuse. Although some women may feel safe only with a female counselor, many male counselors can provide effective treatment if they give adequate attention to abuse issues and their own reactions to clients. Furthermore, sensitive handling of the case by a male who does not exploit the client can provide a new, positive male role model. Whenever possible, the client's preference regarding the counselor's gender should be respected; unfortunately, many facilities do not have adequate staffing to allow choice. In such situations, it is important to openly acknowledge the client's feelings and validate them as understandable reactions. This can reduce feelings of helplessness and help prevent the client from leaving treatment prematurely.

Dealing With Disruptive or Dangerous Behavior

Clients in treatment for substance abuse may act rebelliously or violently, a situation that can be exacerbated by an undisclosed history of child abuse. Counselors working with this population have sometimes been victims of physical assault or other violence by clients. It is the program's responsibility to be aware of and inform counselors of any client's history of violence (which may be more common among adolescents in substance abuse treatment). Counselors should have a personal safety plan, and policies should be in place that require them to call law enforcement and press charges if they are threatened.

As well as taking steps to ensure their own safety, it is the responsibility of counselors to create and maintain a safe environment in which clients can explore and address issues. It is the client's responsibility to behave in ways that do not threaten others either physically or emotionally. Early in treatment—at the very outset, if it is a group setting—counselors should communicate and enforce ground rules about how clients can safely and appropriately deal with anger and other feelings of discomfort. Knowing what is expected of them and the other group members contributes toward their experiencing the group as a safe place to share and be heard. Ground rules should include maintaining members' confidentiality and not sharing any information outside the group, no threats or acts of violence, no verbal abuse, no interrupting other members, and no disruptive behavior. Counselors can help clients learn how to express their feelings constructively by validating their *affect* but not their *expression* (if it is abusive or violent).

Abuse survivors commonly are concerned about their safety—or their potential reactions to others—while reliving painful events. Counselors can help clients face these feelings by reinforcing the present safety of the counseling environment. In a calm voice, the counselor should ask clients to explore rather than act out anger or disruptive behavior. The goal is to emphasize to disruptive clients that their feelings are acceptable as long as their behavior remains appropriate. Clients are allowed to have angry feelings—and verbally express them—but they are not allowed to hit anyone, to throw things, or be otherwise violent or disruptive. In this way, clients can be helped to separate their feelings from their actions. The counselor may find that some individuals become caught in obsessive loops, unable to let go of the precipitating issue or to stop being angry. In some cases, this can indicate hidden problems that may need to be explored further (i.e., for possible referral to a qualified medical or mental health professional), such as obsessive–compulsive disorder, PTSD, or bipolar disorder. Constant rage can be a symptom of manic depression or bipolar disorder.

Counselors can help create a safe atmosphere for clients and reduce acting out by practicing "grounding" techniques such as the following:

- *Anchoring/grounding*: Have the client sit in a relaxed posture in a chair with eyes closed (or open, if he is uncomfortable closing them), focusing on his breathing. Ask him to concentrate on feeling the chair supporting his weight and the floor underneath his feet. Have the client recognize how grounded he is in the present. No matter how anxious he may become reliving moments from his past, he is still safe and grounded in the present. (The counselor should be aware of the hypervigilance characteristic of abused clients and not make any sudden moves, or get up out of a chair while the client has his eyes closed; the issue of personal safety is paramount for most of these clients.)
- *Mirroring*: Practice breathing techniques with the client, having her synchronize her breathing with yours. These techniques will relax the client. (This exercise may have intimate overtones that could confuse clients with transference issues, and counselors should be selective in its use.)

- *Timeout*: To stop the current action or behavior pattern, allow the disruptive client to leave the room for a few minutes.

The counselor must take care to avoid joining in the client's disruptive behavior in any way. Disruptive behavior can best be contained if the counselor stays in his role, maintaining calm, comforting, reinforcing behavior that is appropriate for the approach and setting. However, it is appropriate to use authority and security personnel when physical harm is threatened.

Avoiding the 'Rescuer' Role

Because of strong countertransference reactions, coupled with a desire to meet clients' needs, the counselor may want to defend or "rescue" clients. He may offer too much advice or even concrete assistance, viewing clients too narrowly only as victims of mistreatment. A counselor who is not self-aware or does not hold himself accountable for his own personal emotional health may feel that he is the only one who really knows or understands his clients. He attends too many meetings, provides sponsorship, helps clients with child care, lends them money, or dismisses fees.

Counselors must deal with their own strong feelings in an environment separate from the client–counselor relationship so that they do not confuse their own issues with the clients'. If the counselor notices that she is being placed in the "rescuer" role, it is recommended that this be directly addressed with the client. A client may in fact be comfortable in the victim's role and try to manipulate the counselor to intervene and rescue her in a variety of situations.

If the counselor does take on the rescuer role, clients do not learn about personal responsibility and how to deal with resolving conflict and issues on their own (see Whitfield, 1993). Furthermore, clients may become angry when a misguided counselor crosses the line without the clients' permission by intervening in family relationships in an attempt to rescue or defend them. When this happens, the counselor not only has lost the ability to help his clients but also is likely to cause additional harm. Rescuing may give the counselor a temporary relief from her own feelings of helplessness and anger, but it does not lead to positive outcomes for the clients. Clients will best be served by facilitating the development of empowerment. This may mean that the counselor allows clients to flounder at times.

Clients may sometimes report becoming involved in relationships that are clearly dangerous from the counselor's perspective. This often reflects the tendency for abuse survivors to be assaulted or abused again after the initial incident or period of abuse. Although the counselor may be tempted to directly advise a client against such a relationship, it is far more useful to work with the client to explore any propensity to excessive risks or self-endangerment. The counselor's role is to help clients understand their vulnerability to revictimization and to empower clients by helping them recognize that they have the ability to set boundaries with others and no longer have to remain victims. Rescuing clients will not serve the longer term purpose of helping clients develop personal respect and safe boundaries free from abuse and violence. (See TIP 25, *Substance Abuse Treatment and Domestic Violence* [CSAT, 1997b].)

Recognizing Professional Limitations

The counselor must recognize when she is unable to work with a specific client. She cannot benefit clients who are abuse survivors if their issues cause her personal difficulties to the point where her own effectiveness is compromised. Any counselor working with adult survivors should seek support and some form of supervision to review her feelings about the issues brought up by her clients. At the same time, it is the agency's responsibility to ensure that clients are receiving adequate, professional care. From an ethical standpoint, it is better for counselors not to work with abuse survivors at all than for them to take on such challenges if they are not yet equipped to deal with these issues.

If a counselor cannot work with a particular client, he should refer the client to a counselor who is better suited to that individual's needs. Such transfer must be done after discussion with the client, and any issues that arise as a result of the transfer (such as the client's possible feelings of rejection) should be addressed in therapy, both before and after the move. It may be advisable to get an understanding in writing that states that the client knows that treatment with that counselor has ended, at least for the time being. This closes the contract, may lessen abandonment issues, and can help protect the counselor if the client later claims abandonment.

Responsibility of the Agency To Support the Counselor

Alcohol and drug counselors are often subject to great stress. They can be expected to function well and provide effective treatment only if their agency's leadership gives them the appropriate support. Such support includes recognition for and appreciation of the role of the counselor and the stresses it entails. As noted throughout this chapter, this is especially important when counselors are treating clients or families who have a history of child abuse or neglect, because the complexity and number of issues increase, as does the number of systems that must be dealt with. The agency's leadership should strive to impart a sense of vision to staff members that communicates how important their work is as part of the larger effort to break the cycle of abuse and neglect and their impact on society.

The Consensus Panel makes the following recommendations about how the agency can support the counselor:

- Provide a sense of mission.
- Provide (or facilitate) ongoing clinical supervision—if possible, by someone with a specialty in the area of child abuse and neglect.
- Provide trauma training to the counselors that standardizes the procedures for handling trauma cases.
- Empower staff members by encouraging them to share their ideas on improving the program and incorporating, as appropriate, those ideas that enhance the stated mission of the agency.
- Support staff members in their efforts to stay within the limitations of their roles so that they do not take on responsibilities likely to lead to burnout.
- Support staff members in their efforts to keep caseloads at manageable levels and, at the same time, work to educate managed care about the drawback of limiting the length or intensity of services.
- Model the supportive role that the agency wants the counselors to have with their clients.
- Allow counselors unstructured time to talk to each other to give and receive support.
- Train staff on such topics as new assessment tools, research findings, suicide intervention, crisis and nonviolent management of assaultive behavior, and liability issues related to abuse and false memory accusations.
- Bring in an outside professional occasionally to hold a group session with the staff (this can encourage staff members who have been holding in or minimizing the impact of their work on themselves to open up).
- Recognize and reward the work of the staff on a regular basis (e.g., award ceremonies to

recognize ongoing and special contributions).

- Hold regular social events (e.g., picnics, softball games).

If staff members are given opportunities to grow, they will stay motivated and will be less likely to burn out. The agency can provide ongoing training to increase counselors' expertise in specific areas, such as preventing relapse and dealing with stress. It is important to solicit input from staff members on what issues are compelling to them—asking, for example, what they perceive to be the sources of their burnout, then get their recommendations regarding how to address it most effectively; they are often the best resources in this situation. Administrators also need to be familiar with managed care guidelines and other funding streams to ensure adequate income for the agency to support the treatment staff and the services it provides. The process of involving staff members in resolving the problem may help to empower them—which, in and of itself, can be a corrective measure. A flexible organizational structure that encourages an atmosphere of mutual purpose can help reduce turnover rates, increase staff morale, and contribute to a program's total effectiveness.

5 Breaking the Cycle: The Substance-Dependent Client as Parent/Caregiver

Many adults with substance abuse disorders were abused or neglected during childhood. Although most do not abuse their own children, they are at increased risk of doing so (Kaufman and Zigler, 1987). When children who are victims of maltreatment become adults, they tend to repeat a dysfunctional cycle and often lack mature characteristics: the ability to trust, to make healthy partner choices, to manage stress constructively, and to nurture themselves and others (Magura and Laudet, 1996). In addition, substance-abusing women report higher rates of childhood sexual abuse than non–substance-abusing women, and these women report increased episodes of abuse from their adult partners as well. Domestic violence is a reality in many of these families (Browne and Finkelhor, 1986; CSAT, 1997b; Ryan and Popour, 1983). Research shows that childhood maltreatment has developmental, behavioral, and emotional consequences that continue into adolescence and adulthood. Researchers are now examining childhood abuse and neglect as an indicator of the potential for substance abuse (Feig, 1998; Felitti et al., 1998; Whitfield, 1998). For example, one study (Felitti et al., 1998) found that medical patients with adverse childhood experiences (i.e., traumas) had a higher incidence of health disorders, including problems with alcohol (7.4 times that of control patients) and problems with illicit substance use (from 4.7 to 10.3 times that of the controls).

Sheridan proposes a model of intergenerational substance abuse, family functioning, and abuse and neglect that reflects both the direct and indirect relationship between parental substance abuse and family dynamics, child and adult maltreatment, and second-generation substance abuse. She indicates that unless effective intervention occurs, there is an increased likelihood that these patterns will be repeated in the next generation (Sheridan, 1995). Parental substance abuse presents not only a risk for intergenerational transmission of substance abuse disorders but also substantial risk for repetition of problematic parent–child interactions, including abuse and neglect (McMahon and Luthar, 1998a). These studies indicate increased risk factors, and counselors should not assume that their clients with histories of child abuse are mistreating their own children. The family system may function well enough when stress is low. Substance-abusing parents are already severely hindered in their ability to provide a safe and nurturing home to their children (U.S. Department of Health and Human Services [DHHS], 1999); increased stressors such as loss of jobs, poverty, and illness will only exacerbate the situation.

Who Abuses and Why

Nearly one fourth of physical abuse and more than half of sexual abuse of children occur at the hands of adults who are not the victims' birth parents. They may be other relatives, caregivers, or partners. The likelihood of this kind of abuse is far greater when parents are using substances and, consequently, cannot provide adequate care for and supervision of their children (Reid et al., 1999). However, because most child abuse occurs within families, the discussion here will focus on parents. Providers should also note that most child sexual abuse is committed by males (Finkelhor, 1994).

Research on parenting styles and attitudes of abusing parents indicates several distinct characteristics shared by parents who abuse their children. These include seeing child rearing as difficult and not enjoyable, using more controlling disciplinary techniques, not encouraging the development of autonomy in children while maintaining high standards of achievement, and promoting an isolated lifestyle for themselves and their children (Briere and Elliott, 1994). Observational studies indicate that abusing parents are less supportive, affectionate, playful, and responsive to their children and are more controlling, interfering, and hostile; they have fewer pleasant interactions with their children (Magura and Laudet, 1996). Abusive parents tend to "parentify" their children, expecting them to take on the role of caretaker. Because they do not have sufficient knowledge of child development, their expectations of their children's behavior are often too high, leading them to adopt inappropriate disciplinary practices (Wegsheider, 1981). In fact, most abusing parents do not help their children adapt to the major developmental tasks, such as regulating their sleep habits, preparing them to separate from their parents, enabling them to explore their environment safely and with appropriate limits, and making choices and becoming more independent (Levy and Rutter, 1992; Mayes et al., 1997; Rodning et al., 1989). Nor do these families successfully resolve issues of attachment, emotional regulation, autonomy, peer competence, or school and work competence (Cicchetti and Lynch, 1993).

Damaged Parents: An Anatomy of Child Neglect (Polansky et al., 1981) summarizes the characteristics of abusing parents identified by researchers in several different studies:

- The prevalence of poverty, substance dependence, mental illness, and large numbers of children per family
- Feelings of inadequacy and self-reproach, often related to early negative experiences
- Depression, difficulty putting sadness and needs into words, and anxiety discharged into activity
- Serious arrest in development, a sense of incompleteness resulting from a failure to internalize a separate identity (manifested by clinging to children), the presence of other abusive and unfulfilling relationships, and an inability to tolerate being alone
- A fear of taking responsibility and making decisions
- Severe difficulties in verbal communication
- Difficulty in seeking or obtaining pleasure
- Extreme narcissism, gross immaturity, dependency, and an impaired ability to empathize with a child's needs

The Polansky study cautions against overgeneralizing neglectful or abusive parents. Also, it is important to remember that poverty may be a common characteristic because poorer parents are more likely than affluent parents to be involved in public systems, which are mandated to report abuse cases. (Affluent parents tend to access private systems in which reporting is not required.) Nonetheless, the development failures above can signal to a counselor both a potential risk for child abuse and the possible effects of maltreatment in a parent's past.

At the same time, certain resiliency factors have helped many children avoid the cycle of abuse. These include being able to fantasize about another time or place, being able to read and learn about a better time and place, realizing that they are not responsible for the abuse directed at them, and having an adult in their life for a considerable period of time who sees them in a positive way. Resiliencies can be grouped in the following seven categories (Wolin and Wolin, 1995):

- ***Insight*** begins with a sense that life in the troubled family is strange. Such insight can eventually protect the child from a tendency to internalize family troubles and feel guilty.
- ***Independence*** is the child separating herself from the troubled family.
- ***Relationships*** fulfill needs that troubled families cannot meet.
- ***Initiative*** is the desire to overcome feelings of helplessness that a child can succumb to in the troubled family.
- ***Creativity*** is the ability to take pain and transform it into something artistic and worthwhile.
- ***Humor*** allows the child to make the tragic into something comic and laugh at his emotional suffering.
- ***Morality*** is developing a set of principles that differentiates bad from good both inside and outside the family.

Traditional models of parenting may serve as a useful context for understanding how a client views his own parents and the implications for repeating their behavior. The three major types of parenting styles have been described as authoritative, permissive, and authoritarian (Baumrind, 1971). The *authoritative* parent maintains reasonably close supervision, sets consistent standards, and keeps track of children without being overly directive. A *permissive* parent allows children to do as they please and sets few limits or guidelines, which may result in safety problems; this is often a neglectful parent. The *authoritarian* parent is directive and rigid and relies on punishment as a major disciplinary method; within this model, this is often an abusive parent. However, parents typically combine these styles when interacting with their children, and the effectiveness of the approach used depends largely on the family's culture, community, and environment.

Paradigms from developmental literature can also be useful in understanding the effects of environmental disturbances on the maltreated child. Belsky's ecological model, for example, contains four levels of analysis: (1) individual development, (2) family systems, (3) community, and (4) culture, all of which interact with each other and influence whether or not maltreatment will take place (Belsky, 1993). As this model shows, alcohol and drug counselors must understand the broader context of the forces that influence clients and their families. In turn, the counselor can help clients sort through those forces—family, neighborhood, community, or culture—to gain a better understanding about what is and is not good within their environment.

Causes and Context of Parental Abuse

While most research has focused on repeat offenders, there is some knowledge and speculation about how certain dynamics and behaviors are integrated to shape an abusive personality. A common pattern of parent-child relationships is characterized by a high demand for the child to perform in order to gratify the parents and by the use of severe physical punishment to ensure the child's proper behavior (Pollock and Steele, 1972). Abusive parents also may be highly vulnerable to criticism, disinterest, or abandonment by their spouses or significant others, or to anything else that might reduce their already low self-esteem. These types of events produce a crisis of unmet needs in the parents who then expect the child to provide gratification. Unable to meet these parental expectations, the child is punished excessively (Pollock and Steele, 1972).

This pattern of overly aggressive and demanding behavior is often rooted in the parent's own childhood. Many abusive parents report that they were raised in a similar way, and these types of childhood experiences provide "lasting imprints" that are reflected in the way the adults feel about themselves and their children. More recently Dutton, in *The Psychological Profile of the Batterer*, has identified characteristics such as the presence of a "shaming father" and the need for children to be excessively mature as factors that contribute to the personality of the batterer (Dutton, 1995).

Role of the Counselor

Alcohol and drug counselors can play an important role in helping to break the cycle of child abuse and neglect that often plagues their clients. Many times, parents who were victims of abuse or neglect as children express strong concern and anxiety about the possibility that their children may be abused. By working closely and empathically with a substance abuser, the counselor has the opportunity to break the cycle.

To help determine whether a substance-dependent client is at risk for child abuse, the treatment providers should become familiar with the client's childhood—her parents' style of child rearing, family dynamics, possible traumas, and other events that may serve as a predictor for child abuse or neglect. At the same time, the counselor also needs to learn about the client's current family life, particularly parenting behaviors that provide some clues as to whether the client's children are at risk.

This information—along with the counselor's awareness of a broad range of parenting situations, cultural backgrounds, systems, social supports, and treatment options—will enable the counselor to better assist clients and their children. Although counselors can play an important role in breaking the cycle of child abuse and neglect, they cannot do this alone. They are only one part of the continuum of care that is needed to break this cycle. For this reason, treatment providers will need to reach out and work with child welfare systems, school systems, child guidance clinics, health care providers, and others so that parents who abuse substances get the help they need and do not abuse or neglect their own children.

While women with substance abuse disorders have often been the focus of interventions, breaking the cycle of child abuse and neglect also means including fathers who are at risk for neglecting or abusing their children, as well as significant others and family members who may share caretaking responsibilities. The recommendations offered in this section apply to all clients responsible for the welfare of children.

Learning About the Client's Childhood

A client's childhood can offer information that can be useful in understanding the nature of current family relationships. There are important issues that can be explored tactfully, without necessarily using specific psychology or health care vocabulary. Asking questions about these concerns in a respectful manner helps develop a good relationship between the client and counselor. Although a counselor cannot change the past, she can help the client find the strategies to improve her current situation and the strength to recover. Many of the questions that follow may be asked during assessment, but they can also be rephrased and asked again in treatment. These questions are merely guidelines that should be modified to fit the needs of each particular client.

- What do you know about the circumstances around your birth?
- What was your infancy or early childhood like? How did your parents describe you and those times?
- What was your relationship with your mother or father like? Tell me about any special times with them.
- Did anyone in your family (including aunts, uncles, cousins) use alcohol or drugs? Do you personally feel that they had an alcohol or drug problem?
- Did any family member ever undergo treatment for alcohol or drug use?
- Who raised you as a young child? Who was important to you when you were growing up?
- Did you have any serious medical problems when you were growing up? Were you ever in the hospital?
- How were you disciplined when you did something wrong? How did your mother, father, grandparent, or other caregivers reward you?
- Were your parents involved and interested in your life and activities? Did it feel like they knew what you needed and what was important to you? How did your parents show you their attention, affection, and appreciation? (These questions will help to identify patterns of neglect.)
- As a child, did you like school? Were there any specific school issues regarding attendance, grades, or behavior? Did you graduate from high school?
- Did your family move a lot as a child? Did you go to several schools because of frequent moving?
- How well did you get along with your peers and teachers?
- What was the relationship between your parents like? Were they divorced or separated while you were growing up? Was there ever violence involved when they were upset with each other?
- How old were you when you started having sex? How many times have you become pregnant or impregnated someone else? How did you handle each pregnancy? Did you keep the child?
- Was a child protective services (CPS) agency ever involved in your life? Were you ever taken out of the home? Did you ever have a caseworker?
- Did anyone in your family ever have trouble with the police?
- Do you remember any particularly frightening experiences as a child?
- Did anyone in your family ever have an emotional problem, like depression?
- As a child, what did you do for fun? What do you do for fun now?
- Did you attend church regularly as a child?
- Did spirituality or faith play a significant role in some other way as you were growing up?
- How do you get along with your own children now? Could you describe any special times with them?

These interviews should not be hurried. The counselor should make sure that the client is comfortable and that the meeting area is quiet and peaceful. Some questions or topics may need to be reserved for a later time when the counselor has developed a more trusting relationship with the client. (Besharov, in *Recognizing Child Abuse: A Guide for the Concerned,* provides guidelines for interviewing parents who are at risk or are suspected of maltreating their children that can be adapted by treatment providers [Besharov, 1990].) (See also DePanfilis and Salus, 1992.)

Learning About the Client's Current Home Life

In treating a client with children, the counselor will naturally learn how much of an impact

Socioeconomic and Cultural Differences

It is important that counselors not mistake class and cultural differences for child abuse or neglect. Many practitioners may not appreciate the limitations imposed by poverty and cannot distinguish between neglectful practices and those that are caused by lack of money and education. (Family problems of poverty may require referrals for cash assistance or concrete services for heat, clothing, or food.) For example, in some communities it is not uncommon for preteens to babysit infants. A seemingly disorganized house does not necessarily reflect uncaring parents. It is also important for counselors not to overreact to cases of social deprivation in poor families. While poverty may expose the parents to more risks for child abuse, most poor families do not abuse or neglect their children (Besharov and Laumann, 1997). A comprehensive assessment must be made before any conclusions are reached. At the same time, the counselor needs to make clear to the client that although certain behaviors may be more acceptable in other cultures, if those behaviors inflict emotional or physical pain and interfere with the normal growth and development of a child, they are considered abusive here.

parenting is having on the client's substance abuse. In the best of situations, parenting is stressful. For those whose own parents were not good models, it can be particularly difficult.

Parents who abuse substances are not a homogeneous group. They have a range of experiences and a range of parenting skills (Howard, 1995; Tyler et al., 1997). Some of these parents have been abused and neglected during childhood. Others may not have been abused or neglected but have been raised by parents who did not have adequate parenting skills. Both groups have been exposed to poor models of parenting.

Counselors are treating individuals with serious addictions that interfere with their normal daily activities and mental states. Taking illicit drugs requires parents to focus their energies on procurement. Parental priorities are not their focus; rather, the parents are focused on a need to care for themselves. Although the majority of these parents express feelings of caring and concern for their children, the addiction supersedes all other concerns. When under the influence of mind-altering drugs, such as cocaine and methamphetamine, parents are unable to foster whatever nurturing and sensitive parenting behaviors they may have.

By having clients describe their current home life, the counselor can gain additional insights into their degree of risk for child abuse or neglect. Treatment providers should learn about clients' current supports (i.e., family, teachers, counselors), as well as whether they are having financial problems, living in substandard housing, or unable to pay rent or provide medical care for their children. Some specific questions that can be asked include the following:

- Who are the people or groups that give you support? Do you have any special friends? Do you belong to a church, temple, or other religious or community organization?
- What type of social activities do you enjoy? How often?
- Have you been involved in the legal system? When? Have you ever been on probation?
- Who else lives with you at your home? Who else spends time there?
- Describe a typical week. What is your routine each day? On weekends?
- Describe your children's schedules. What do you do with them each day? On holidays?
- Are your children receiving ongoing medical care? Are their immunizations current?

Through these and other questions, the counselor should get a sense of whether clients are at risk of neglecting or abusing their children.

Clues That the Client May Be Endangering Children

In certain treatment settings, such as day treatment centers with child-care services, the counselor may have the opportunity to meet the client's children. Such direct observation can be beneficial in several ways. First, the counselor can see firsthand how the client relates to his children:

- How does the client react to his children's behavior?
- How does he respond to his children's emotional needs? Do his children make eye contact with him? How does he respond to the children's crying?
- How does he praise and discipline his children?
- Are his expectations age-appropriate?

With this information, the counselor can assess the client's parenting style. Some warning signs that these children are in danger of abuse may be obvious, such as a parent hitting a child. Other behavioral signs may include a child's yelling, screaming, not being able to sit still, flinching easily, or attaching indiscriminately to others. Regression to an earlier developmental stage is not uncommon. For example, a child who had been toilet trained or able to separate well from the parent may suddenly be wetting her pants or clinging to her parent. The counselor should be mindful, however, that these behaviors might indicate developmental problems, such as attention deficit/hyperactivity disorder. Whatever the case, the child should be referred to a health professional.

The counselor will also have an opportunity to check for any signs that could result from physical abuse or neglect. The counselor can see if the children are underweight for their age or if they are unkempt. The counselor can observe whether the child has any exposed bruises, cuts, or obvious fractures. The counselor can then ask the client to explain why the child is underweight or injured. If the client's explanation is suspicious and the story does not fit the child's physical status or injury, then the counselor would have cause to report this to a CPS agency (see Chapter 6).

In most treatment settings the counselor does not have the opportunity to meet the client's children. Over time, however, the counselor will learn more and more about the client. In an unguarded moment, the client may begin describing parenting behavior that is not appropriate. The client may also share something in group or via writing exercises. Figure 5-1 lists some examples of poor parenting behavior that could lead to child abuse or neglect.

In situations where poor parenting is indicated but the client does not appear to be abusing or consciously neglecting the child, the treatment provider will need to direct the client toward those agencies and services that can help her become a better parent. At the same time, the counselor can talk about and reinforce good parenting practices.

Incorporating Treatment Strategies for Child Abusers

Breaking the cycle of abusive parenting means understanding the background of the parent within the context of the family, neighborhood, and culture. When parents who abuse substances recall their own childhood, they often report deprivation in many areas—

Figure 5-1

Behavioral Clues That Suggest Possible Child Abuse or Neglect

- **Name calling, verbal abuse, negative or belittling labeling of the child**
- Stories that suggest children are living in unsafe conditions (e.g., spoiled food, being left alone, traveling in unsafe neighborhoods)
- Blaming children or directing misplaced anger on them that may mask guilt about poor parenting
- Describing children inappropriately in terms of their development (e.g., having expectations for a 4-year-old that should be reserved for a 12-year-old)
- Giving children too much responsibility and autonomy for their age
- Sexualizing the child
- Insisting that the child is just like one of the parents (i.e., negatively describing him)
- Negative behavior on the part of a new partner in the caregiver's life
- Inappropriate disciplinary measures; an inability to distinguish between discipline (guiding) and punishment (hurting)

emotional, social, physical, and economic. If these parents recall histories of severe neglect or abuse during childhood and adolescence, the counselor can assume that most have missed out on opportunities to form healthy, trusting relationships with their caregivers and have not experienced a model of parenting that included a consistent, nurturing environment with appropriate roles and boundaries. The first thing substance-abusing parents typically need to focus on is how to build positive relationships with their children. Because many clients' parenting skills and styles reflect what they have experienced, they will be at an increased risk of parenting inappropriately, and some within this group will abuse or neglect their children. Most of these parents want to do the best for their kids—they just don't know how. Therapists should support their clients' desire to become better parents and assist them in identifying parenting support programs.

Just as counselors can expect that substance-abusing parents often will deny their substance abuse, they can also expect parents to deny neglecting or abusing their children. The challenge for the counselor is to help parents understand that their parenting behaviors may not be appropriate and that these behaviors can negatively influence their children's future development, especially their ability to trust others and to develop self-esteem and pride about their lives. When parents lack a reference point—that is, good parenting models—they will need help in

- Recognizing the importance of appropriate parenting behaviors
- Seeking help to become better parents
- Identifying others who can support them over time as they parent their growing children
- Understanding how current abuse of substances affects responsible parenting

At the same time, the counselor must not forget to articulate the positive aspects of the clients' experiences. Focusing on the negative or risk factors only results in shame and futility and is counterproductive. Increasing clients' self-esteem and self-efficacy (their effectiveness and ability to take responsibility) is a primary step to their understanding of the child-rearing role. Thus, it is important for the counselor to praise clients when they act according to appropriate parenting behavior—and point out that this shows they do have the qualities of a good parent within them. This will develop a trusting and helpful relationship with these clients. It will also help them break the cycle of shame by offering some strategies of hope.

Indeed, there is evidence suggesting that substance-abusing parents are aware that their parenting strategies may be counterproductive and worthy of change (Hawley and Disney, 1992; Levy and Rutter, 1992) and that they are highly concerned about the well-being of their children (Grossman and Schottenfeld, 1992; Tunving and Nilsson, 1985). The counselor's relationship with clients also provides a positive model for the client of what constitutes a helping relationship. Consciously or unconsciously, clients may adopt techniques they experienced as significant in their own therapy when interacting with their own children—reflective listening, setting appropriate boundaries, treating others with respect, and providing encouragement and positive reinforcements, among others.

What Abusing Parents Should Learn

To raise a child in a nonabusive and nonneglectful manner, it is important that parents have the basic knowledge and skills needed, including the following:

- Realistic knowledge about child development
- Parenting skills
- An understanding of the impact of child abuse on a person
- Good relationships with spouse and other adults
- Other personal development and social skills development

Treatment programs should establish guidelines on how to deal with these issues if they arise during counseling and know when to refer clients for appropriate types of intervention and support, such as child development and parenting specialists.

Additionally, there are many types of support groups available for parents and children involved in abusive relationships. Parents Anonymous, for example, is intended to help adults who abuse children. Parents Anonymous also targets families who have been involved in incest and attempts to keep these families intact or reintegrate families that have been divided because of incest. Alateen, another 12-Step group, is designed for older children whose parents are alcohol dependent and who may be at risk for abuse.

Realistic knowledge about child development

Parents should understand the stages of child development and the expectations reasonable for children at specific ages. (An organization in Washington, D.C., called "Zero to Three" [see Appendix E] develops materials, including posters and wall charts, for parents and child care practitioners that define and explain key stages in the development of children from birth to age 3.) Abusive parents often believe that very young children (i.e., 2- or 3-year-olds), can stop crying on command, take care of themselves, and respond maturely to the caregiver's needs (Peterson et al., 1996).

Parenting skills

At-risk or abusive parents probably need help in basic child-rearing skills, such as how to use effective disciplinary behavior, how to reward, and how to effect desired responses.

An understanding of the impact of child abuse on a person

A number of resources are available that can help clients learn about the consequences of child abuse. "Choices" is avideotape produced by the Center for Substance Abuse Prevention that features interviews with parents who were victims of child abuse. The Public Broadcasting Service has produced several special programs on child development that are available on video. A book of therapeutic stories, such as *Once Upon a Time: Therapeutic Stories To Heal Abused Children* (Davis et al., 1990), which can help heal the damage of abuse, can be read to children or given to parents to read. If adults at risk for abusing children were also victims, they should understand why they were abused (e.g., their own parents did not know about child development stages) if they are not to become abusers themselves.

Good relationships with spouse and other adults

A mother's satisfaction with her spouse and her sense of support from friends and from the community contribute greatly toward a positive attitude about parenting. Strengthening these relationships helps to increase the possibility of improved maternal caregiver behavior (Belsky, 1984) and may prove helpful for fathers as well. Developing interpersonal skills is an issue that can be addressed in therapy and also in marriage counseling.

Other personal development and social skills development

These include stress management, assertiveness training, and the development of self-confidence. Learning such skills as managing stress and knowing how to deal with anger may lower the risks of abusing a child.

Selecting the Most Effective Treatment Program

Data suggest that interventions aimed at breaking the cycle of substance abuse, child neglect, and maltreatment are more successful when they are family centered (Magura and Laudet, 1996). Critical services that may need to be provided for parents who abuse substances include

- Access to physical necessities, such as food, housing, and transportation
- Medical care
- Counseling on substance abuse prevention
- Training on parenting and child development
- Training in child care techniques (bathing, holding, packing a diaper bag, giving medication, etc.)
- Social services, social support, psychological assessment, and mental health care
- Family planning services
- Child care
- Family therapy and health education
- Life skills training in such areas as financial management, assertiveness training, stress management, coping skills, home management, anger management, conflict resolution, and communication skills
- Educational and vocational assessment and counseling
- Training in language and literacy
- Planned, continuing care after program completion

If clients are to receive appropriate help, it is essential that the treatment match their current abilities to function rationally and to be good parents. Other factors, such as clients' social class, culture, and resources, must also be considered. By addressing these issues, counselors can place clients in community-based treatment programs that address their clients' particular needs. For example, it is important in family therapy to plan what will be discussed when children are involved. The family therapist will understand the developmental needs of the children and, when appropriate, will provide information to the children about the nature of substance abuse, dependency, and treatment. The recovery process of clients can also be addressed.

Parenting classes and support around parenting, recovery, and parent–child relationships can be explored. This can be based on the licensing and credentials of the counselor. Usually in early recovery, family education and counseling around recovery is helpful. Later in recovery, more in-depth family therapy may be called for, and a systems approach can be taken. However, when domestic violence is occurring, a systems approach is counterindicated. When a CPS agency is involved, a team approach that coordinates treatment plans is essential. See TIP 25, *Substance Abuse Treatment and Domestic Violence* (CSAT, 1997b) for more on this issue.

Clients with children will fall into two general categories: those with custody and those without. At intake, the treatment provider should find out which situation pertains to a client. To give appropriate guidance for both groups, the counselor should learn the following about the client:

- Current substance abuse (and means of procurement)
- Substance abuse by a significant other who may be involved in child abuse or neglect allegations
- Treatment plan to reduce substance abuse
- History of deprived childhood
- History of child abuse and neglect
- History of involvement with CPS agencies or court system
- History of out-of-home placement
- Attitudes about parenting, knowledge about child development, and awareness that parenting tasks change depending on the age of the child

Standardized screening measures are available to provide a second source of information on clients' attitudes toward parenting and potentially problematic areas: The Parental Acceptance and Rejection Questionnaire (PARQ) discussed in Chapter 2 has an adult version completed by the parent about her relationship with her child as well as a child version completed by the child about his parent. The Parent-Child Relationship Inventory (PCRI), also discussed in Chapter 2, is another instrument that can help clinicians explore their clients' potential problem areas in parenting.

Treating parents with custody

Studies show that the overwhelming majority of minor children affected by parental substance abuse remain in the custody of their parents (Feig, 1998). When dealing with parents who have custody of their children and who have reported a past history of deprivation, neglect, or abuse, the counselor will need to determine the safety of the children and the support available to the client. Some clients may not have custody of their biological children but are living with or dating someone who does and therefore has a caregiver role. At intake, the counselor should make clear to a client that she is concerned about the client both as a person with a substance abuse disorder and as a parent with certain responsibilities. The counselor needs to state from the beginning that both the client's and the children's safety are of utmost importance. To understand the situation better, the counselor will need the following information:

- The children's daily schedule and the adults involved in their care or supervision
- The children's current health status
- The client's involvement with other agencies, such as family preservation, back-to-work, and job training programs
- The role of a significant other in the care of the children, his attitude toward the children, and any previous history of abusive or neglectful behavior toward children
- Previous or ongoing involvement with CPS agencies, the reasons for involvement, current child protective system plan, and outcomes from previous involvement with CPS agencies

Once this information is obtained, the counselor should determine the client's daily and weekly activities. This is important in understanding the stresses and tasks required of the parent. For example, a client is likely to relapse or escalate drug use if she senses failure or experiences frustration. Therefore, the counselor must help the client to prioritize her responsibilities and tasks, and recognize the need to identify supportive help when possible.

One approach that the counselor may want to consider is to place emphasis on safety. The two words "safety first" can be used to guide all discussions about a client's approach to her daily tasks. By prioritizing tasks based on the parent's and children's safety, the counselor can focus clients on immediate action in a way that is positive and nonaccusatory. By framing the discussion this way, the counselor can help parents understand that it is a safe strategy to stay away from drugs; it is a safe strategy to make sure their children are in the care of a clean and sober adult; it is a safe strategy to make sure that their children attend Head Start or school; it is a safe strategy to keep children's immunizations up to date (Rubin, 1998).

Over time, the counselor will become familiar with a parent's treatment attendance record, the results of random urine toxicology drug screens, and the children's activities and can thus get a sense of the stress and risk factors in the client's life that might lead to abusive or neglectful behavior. The counselor also will learn about the parent's ability to organize a daily schedule for his family and himself, follow through on responsibilities, and acknowledge when these responsibilities may be too daunting. When a crisis in a client's life seems imminent, the counselor will be better prepared to help the client reexamine his priorities and consider, once again, a plan that will provide safety for the children and for him.

Treating parents without custody

Counselors will often treat clients who do not have custody of their children. This group of parents presents some issues that are different from those parents who do have custody. The counselor's initial major concern is not about the safety of the children. Instead, it is about the safety of her clients, addicted parents who need to focus on being sober and on reuniting with their children in a timely manner. The counselor should learn about

- The CPS agency's plan for family reunification and the schedule to complete this effort
- The specific requirements for family reunification, such as the time allowed clients to begin abstinence from or reduction of substance abuse, the visitation schedule with court-appointed caregivers, and completion of parenting classes
- Age, health, and general developmental needs of each child
- Client's history of loss of custody of children and outcomes
- Client's history of drug or alcohol treatment and outcomes
- Client's current drug use, health status, income, and housing situation
- Client's history of childhood deprivation, neglect, or abuse

With the recently legislated fast-track adoption laws and the requirement that courts establish more rigid time lines for family reunification, treatment providers must help the parent to prioritize the tasks that should be done for a successful outcome. For example, the client who acknowledges he must change his substance-abusing behavior to become reunited with his children is setting a priority toward successful family reunification. The counselor must then help the client proceed with this goal, recognizing that as time goes by other issues will need to be addressed and be included in the tasks that are required for family reunification, such as improving his parenting skills, finding appropriate housing, learning about financial planning assistance, and searching for work.

For family reunification to occur, it is critical that the alcohol and drug counselor collaborate with the CPS agency professional to develop a realistic plan for family reunification. Together, they must ensure that the parent is not overwhelmed with too many tasks at one time. Moreover, the counselor must carefully consider the timing of referrals to the appropriate professionals or community-based programs so that the court timeline for family reunification is taken into account.

Treatment Settings

Most substance abuse treatment settings do not have the resources to handle both substance abuse and ongoing child abuse concerns. Interagency networks and agreements can be most effective in these cases. Such cooperative arrangements should include a unified system of case management and clinical review. Following are a few selected programs in the United States that have incorporated both issues under one roof, which can serve as models for creative program development in other communities. The recent study, *No Safe Haven: Children of Substance-Abusing Parents,* (Reid et al., 1999) also reviews some examples of innovative combined services.

Residential programs for women

Residential treatment programs can be exceptionally productive because of the way many women deal with the world. Research suggests that a woman develops in the context of relationships, rather than as an isolated individual (Surrey, 1985). In this model, where relationship and identity develop in synchrony, a woman's role as mother is intrinsic to her personal growth and serves as a motivation to facilitate treatment. Depriving her of children and other personal relationships can be detrimental to recovery.

Parental Awareness and Responsibility (PAR) Village

Located in Largo, Florida, this program admits cocaine-dependent women into a therapeutic community with children younger than 10 years of age. As many as 14 women live in separate residences with their children.

Begun in 1990, PAR Village was originally a research project funded by the National Institute on Drug Abuse (NIDA) to answer the basic question, "Will women stay in treatment longer as a result of keeping their children with them while in treatment for their substance abuse problem?" Women were randomly assigned to one of two treatment programs: one with their children and one without. Results showed that women who entered treatment with their children stayed longer, completed treatment more often, and had more positive outcomes (especially in retaining or regaining custody of their children) than their control group counterparts. As a result, PAR applied for continued funding through CSAT to allow the program to continue its successful treatment models (Coletti et al., 1997).

While in treatment, both control and experimental groups were provided with group and individual counseling, educational and vocational training, parenting and life skills training, medical services, substance abuse education, and relapse prevention. In the original NIDA study, results indicated that positive outcomes increased when women came to treatment with their children. The experimental group had significantly longer lengths of stay. In fact, at 6 months, 65 percent of women with their children were still in treatment, compared to 18 percent of the control group. Posttreatment custody also improved. Half of the women who came to treatment with their children retained or regained custody of their children at the 6-month posttreatment followup, compared to none of the control group.

The Spring

This long-term residential program in Carlsbad, New Mexico, is designed for female substance abusers who have children. This intensive and structured treatment program incorporates psychological, social, educational, vocational, and spiritual aspects of treatment and provides support services for the residents' children and adjunctive family treatment. Each resident shares a private room with her children. The children attend school or day care, and mothers go to classes. Children receive testing and counseling, and mothers care for their children. The comprehensive residential program consists of a broad range of activities, including 12-Step meetings, classes, and therapy groups.

Village South Families in Transition (FIT)

This residential program for women in Miami, Florida, is funded by CSAT and the Ounce of Prevention Fund of Florida. The program allows residents to bring up to five children, from newborns to age 12, to live onsite for 18 months. The FIT program also provides services to adult significant others and nonresidential children. The program includes an onsite child care center, primary health care and support services, drug intervention and prevention services for mothers and children, and counseling on job and life skills, parenting, and mother–child relations. There are family visits and weekend visits, and partners and other family members are involved. If a mother relapses and has to leave, the village can maintain joint custody of the children, and the mother can regain custody later.

Day treatment

Although residential treatment centers have many advantages, parents may find this type of facility disruptive for family members, especially for older children who would have to change schools, lose contact with friends, and have less access to extended family. For many parents, intensive, family-oriented outpatient and day treatment programs are a more feasible alternative.

Family Rehabilitation Program (FRP)

Launched in 1990 by the New York City Human Resources Administration–Child Welfare Administration, this program targets mothers with newborns exposed to drugs (often cocaine) identified by the child protective system. It attempts to prevent the need for foster care of newborns and enable the families to provide for the long-term development of infants and other children. The primary client is the substance-abusing mother, who is offered both substance abuse treatment and intensive social services aimed at preserving the family unit. Services are provided through contracts with community-based volunteer groups selected to provide culturally sensitive services, including home-based visits. Unlike many family preservation programs, which are limited to 60-day interventions, FRP clients participate in services for about 1 year (Magura and Laudet, 1996).

Project Connect

This project is an effort to respond to the needs of both parents and children. It is a collaborative effort between a State department of child welfare, a private nonprofit agency, a school of social work, and a number of substance abuse treatment and health care agencies. Its goals are threefold: to reduce the risk of child maltreatment, to keep families affected by substance abuse together, and to increase the capacity of the local service system to respond effectively to the needs of these families. Funded by a grant from the National Center on Child Abuse and Neglect, Project Connect is administered by the Rhode Island Center for Children-at-Risk in Providence and operates under contract from the Rhode Island Department of Children, Youth, and Families (Olsen, 1995). Families receive services for about 10 months in this program.

Project SAFE (Substance and Alcohol Free Environment)

Begun in the mid-1980s by the Illinois Department of Children and Family Services and the Department of Alcoholism and Substance Abuse, this program focuses on poor urban minority women with children. In this program, caseworkers identify women who have been accused of child neglect or abuse and have screened as high risk for substance abuse. Project SAFE takes a proactive approach by intensively recruiting women into the program. Once clients are in the program, the outreach caseworker calls clients daily, offers transportation, and helps to arrange child care throughout intensive outpatient treatment (Boundy, 1998). (For additional information on Project SAFE, see Chapter 7.)

Relational Psychotherapy Mother's Group (RPMG)

RPMG is a weekly parenting group offered along with substance abuse treatment. RPMG concurrently addresses mothers' unmet psychosocial needs and parenting deficits using a nonjudgmental and supportive therapeutic stance, emphasizing interpersonal relationships with adults and children, and employing a guided-discovery approach to exploring parenting and interpersonal deficits. During a 3-year pilot study, RPMG was tested as an adjunct to standard treatment offered in methadone clinics in New Haven, Connecticut. Compared to mothers receiving standard treatment alone, mothers receiving the supplemental RPMG were at lower risk for maltreating their children, reported higher levels of involvement with their children, and greater parental satisfaction overall. At 6-month followup, in addition to sustaining their gains, the RPMG mothers were less likely to use opiates than comparison mothers. Children of RPMG mothers also showed healthier levels of psychosocial adjustment than children of comparison mothers (see Luthar and Suchman, 1999 and in press).

Incarcerated parents and parents in transition from incarceration

Typically, substance abuse treatment programs in jail or prison settings will limit the presence of children. However, some criminal justice and social service professionals believe that children should have the opportunity to visit their parents in jail. Children typically want to see and talk to their fathers and mothers. Two programs in New Mexico provide such family services. Project IMPACT, at both the Central New Mexico Correctional Facility in Los Lunas and the New Mexico Women's Correctional Facility in Grants, reviews parenting skills of inmate fathers and mothers and provides education programs, counseling, and family visits. The program eases transition back into daily family life and provides community services to inmates' children and spouses during their incarceration. A second program in New Mexico, Comienzos, which means "beginnings," is an education program at the Bernalillo County Detention Center that provides education on parenting, family violence, and related topics. In these cases, professionals found they could motivate parents to become involved in the substance abuse treatment programs while in jail if they had contact with their children. The California Department of Corrections and the Department of Alcohol and Drug Programs support a prison-based program called Forever Free from Drugs and Crime. Forever Free participants live in a separate 240-bed facility and receive treatment 4 hours a day, 5 days a week. Counseling, relapse prevention, and problemsolving and parenting classes are part of the curriculum. For more information, call the California Department of Corrections Office of Substance Abuse Programs at 916-327-3707. For more information on substance abuse disorders and criminal offenders, see TIP 30,

Core Functions of a Child Protection System

- Respond to reports of child abuse and neglect, identify children who are experiencing or at risk of maltreatment.
- Assess what is happening with those children and their families—the safety of the children, the risk of continued maltreatment, the resources and needs of the parents and extended families, and their willingness and motivation to receive help.
- Assemble the resources and services needed to support the family and protect the children.
- Provide settings for alternative or substitute care for children who cannot safely remain at home.
- Evaluate progress of the case during service provision and assess the need for continuing child protective services.

Source: The Center for the Future of Children (Schene, 1998, p. 36).

Continuity of Offender Treatment for Substance Use Disorders From Institution to Community (CSAT, 1998b).

Organizational Roles and The Need for Collaboration

In treating adults with substance abuse disorders who are suspected of abusing or neglecting their children or who are already involved in the CPS system, counselors must communicate and collaborate with representatives from CPS agencies, all while keeping the best interests and confidentiality of clients and their families in mind. Counselors also must understand the role of juvenile, family, and criminal courts in prosecuting cases of child abuse and neglect. Every system attempts to accomplish a specific set of goals to help further the well-being of clients and family members. However, the philosophies and processes used may be very different, and the potential for conflict (expressed or unexpressed) among agency representatives is great. It is important to find ways to collaborate with other agencies in a manner that builds and maintains trust—while continuing to adhere to Federal confidentiality laws. Figure 5-2 presents some suggestions for ways in which professionals from the child welfare and treatment fields can collaborate more closely.

Role of Treatment Providers

The main focus of the treatment provider is to provide interventions and support to help clients with their substance abuse and dependence issues and recover from the physical, psychological, emotional, social, and spiritual harm that their substance abuse has caused themselves and others. However, once child abuse or neglect is known or suspected, legal constraints take precedence because counselors are mandated to report cases to CPS agencies. It is not the role of the treatment provider to investigate child abuse; once the report is made, the provider's clinical attention should shift back to and remain with the client.

It is important for counselors to let clients know from the beginning that counselors must report suspected abuse and neglect because the law requires them to do so. However, the accompanying message to the client should be that even if a report is made, the counselor will continue to work with the client, providing treatment and support. (Counselors should emphasize that it is in a client's best interest to address abuse issues before a child is harmed and before a client has jeopardized her parental rights.) For clients who have been reported, an

Figure 5-2

Strategies for Collaboration

Program planning and administration

- Provide joint training for substance abuse treatment staff and CPS agency workers
- Develop team staffing approaches
- Provide joint funding for services
- Conduct joint goal-setting programs

Case monitoring and ongoing collaborative activities

- Develop jointly sought treatment goals at a case conference
- Improve family risk assessments as they relate to substance abuse
- Adapt monitoring concepts from Treatment Alternatives for Safe Communities and referral and monitoring agencies

Joint treatment

- Use a parenting focus to engage parents in substance abuse treatment programs
- Integrate child development services with substance abuse treatment
- Provide families with long-term services that vary over time
- Involve family members caring for the client's children

Source: Feig, 1998.

extra measure of support may be necessary. For example, although counselors' large caseloads would preclude them from routinely accompanying clients to court, exceptions could be made for some clients.

Even when accompanying clients to court is not possible, the counselor can create strategies to address the upcoming court date and related issues in treatment. For example, clients who abuse their children often have their own abuse histories and may have painful memories of having to appear in court as children to be placed in foster care. Discussing such memories with clients may prove valuable to the treatment process. Helping clients understand the court system and procedures may also strengthen the therapeutic bond. The role of the alcohol and drug counselor often involves teaching clients self-advocacy and communications skills—that is, helping them learn to approach various systems in ways that will produce fruitful results that meet their individual needs.

Role of CPS Agencies

Every State has a CPS system to investigate reports of child abuse and neglect to determine whether the child in question is in danger and to intervene if necessary. The CPS agency initiates a comprehensive assessment of a child's safety and well-being in the family. The assessment can involve interviews with the child, the parents, and other family members; visits to the home to evaluate the environment and family dynamics; contacts with schools and other service providers who are or have been involved with the family; and testing to assess the child's health and development (see Kropenske and Howard, 1994). CPS investigations, foster care placement, and adoption services are different aspects of child welfare services, but these functions are organized and titled differently in various States and municipalities; in smaller (i.e., local) jurisdictions, roles and responsibilities may often overlap.

If the CPS agency determines that a child is (or is at risk of being) neglected or abused, it can initiate family preservation services to remedy the problems (see Figure 5-3). The CPS worker is responsible for developing a service plan to help the family improve in those areas the assessment found lacking. The service plan can cover housing, day care, transportation, clothing, food stamps, parenting training, individual or group counseling (including substance abuse treatment), and teaching the parent basic household skills. These services may be provided while the child remains in the home if the child's safety can be assured, or the child may be removed to foster care while services are provided.

When it is determined that a child is not safe in the home, the CPS agency has the authority to remove a child temporarily and place the child in another living situation, such as foster care or with relatives (i.e., kinship care). Relatively few children are actually removed from their homes (in 1996, children placed in foster care represented 16 percent of CPS cases), and most of those removed are returned to the parents' custody fairly quickly once their safety has been assured (DHHS, 1999; Goerge et al., 1996).

Children who are placed in out-of-home arrangements must wait for the legal system's procedures to take place before a final plan of family reunification or other permanent placement is completed. This plan generally focuses on reuniting the family while ensuring the child's safety and may include substance abuse treatment for parents, as well as other services. The plan and progress toward it are reviewed periodically by the court, and it must be demonstrated to the judge that efforts are being made toward the achievement of the planned goals. Recent Federal legislation mandates that permanency plans be determined quickly and that a permanency hearing be held within 12 months of adjudication of the abuse or neglect. If the child remains in foster care for 15 of the most recent 22 months, the jurisdiction must start the process of terminating parental rights and developing a plan for adoption or kinship care for the child.

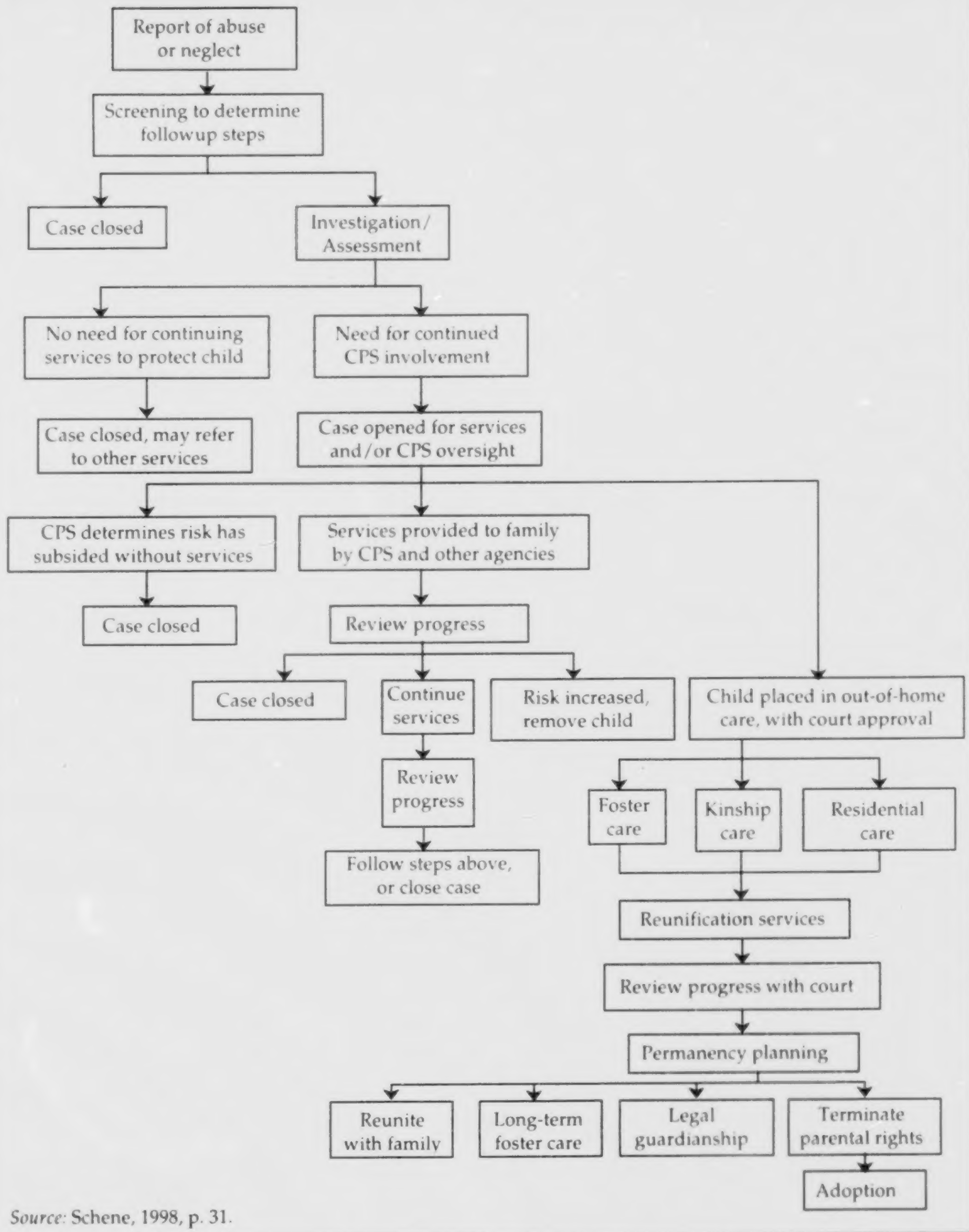
CPS agencies are required to investigate all reports of child abuse or neglect within a short time—generally a week. Unlike other public service agencies, they cannot generate a waiting list when service needs outstrip resources. With increasing reports of maltreatment in recent years, backlogs of uninvestigated cases have grown, and CPS agency caseloads have soared. Many workers are assigned more than 50 families even though standards developed by the Child Welfare League of America (CWLA) call for caseloads of no more than 12 to 17 families (CWLA, 1989; Daro and McCurdy, 1991; Reid et al., 1999).

Role of the Courts

The juvenile or family court judge has several placement options, which vary slightly by State. These are reunification with parents, adoption, or guardianship (often with a relative). Children aged 16 and above might enter an independent living program. After reasonable efforts are made at reunifying the child with the family within the timeframe stipulated by law, the court can terminate parental rights and free the child for adoption. Juvenile and family courts have heavy caseloads, and judges sometimes hear a new case every 15 minutes (General Accounting Office, 1999).

Some child abuse perpetrators are charged in the criminal court, which is generally more crowded and slower than the family court system. In some cases, families may be involved with both courts. In those cases, the juvenile or family court judge may decide to delay a

Figure 5-3
Overview of Steps Through the Child Protective Services and Child Welfare Systems


Report of abuse or neglect
Screening to determine followup steps
Case closed
Investigation/ Assessment
No need for continuing services to protect child
Need for continued CPS involvement
Case closed, may refer to other services
Case opened for services and/or CPS oversight
CPS determines risk has subsided without services
Services provided to family by CPS and other agencies
Case closed
Review progress
Case closed
Continue services
Risk increased, remove child
Child placed in out-of-home care, with court approval
Review progress
Follow steps above, or close case
Foster care
Kinship care
Residential care
Reunification services
Review progress with court
Permanency planning
Reunite with family
Long-term foster care
Legal guardianship
Terminate parental rights
Adoption

Source: Schene, 1998, p. 31.

decision about a child placement case until the criminal court acts.

To make the courts more responsive to families' needs, the Center for Innovative Courtrooms has begun to establish juvenile and family courts that offer a whole range of services. The Center's court in Brooklyn, for example, offers drug treatment as an alternative to incarceration, as well as welfare, domestic violence services, general equivalency diploma programs, and other services to prepare offenders to become productive citizens.

In Hawaii, the West Hawaii Counseling and Supportive Living Project has been designed to assist individuals and families in providing safe and nurturing homes for children. A core team of professionals consists of a clinical social worker, a substance abuse treatment professional, a clinical nurse specialist, a service coordinator, and an agency director. They are the primary service providers who conduct a service needs assessment, provide service coordination, and make referrals to other programs and providers in the community. The goal is to provide families and children with individualized treatment planning and services that are flexible and are delivered in a manner that respects the family and their cultural heritage. The target clientele includes

- Families threatened by their own inability to cope with the current stress in their lives
- Pregnant women and mothers with children at risk of child abuse or neglect due to mental health or substance abuse factors
- Families who require service assessment or counseling to provide a safe, drug-free environment for their children
- Pregnant women and mothers with children seeking a recovery program that may include a supportive living environment
- Pregnant women, mothers, parents, or adults with caretaking responsibilities for children
- Parents whose children may be temporarily living outside the home
- Parents whose parental rights have been terminated and who no longer have custody of their children

Role of the Community

The effects of substance abuse and child abuse are felt by the entire community. Thus planners, policymakers, and administrators are developing collaborative community responses that involve community education and prevention efforts, as well as pooling community resources that support clients' treatment. For example, over the past decade, community leaders in Albuquerque, New Mexico, focused on the growing problem of homeless and "throwaway" youths. Local schools, churches, and neighborhood associations joined together to provide physical space and staff for emerging service programs. Outreach teams were created to work on the streets with youths, and clean and sober drop-in centers and shelters were established. In Connecticut, the Department of Children and Families is facilitating connection among social workers, schools, and hospitals. San Antonio, Texas, has created the Alamo Area Prevention and Treatment Providers (AAPTP) Association. This is a consortium of prevention and treatment providers whose mission is to (1) promote accessible and comprehensive prevention, intervention, and treatment services to individuals and families in the surrounding counties; (2) implement a seamless continuum of care that includes prevention, intervention, and treatment services; and (3) facilitate access to care through advocacy, positive community relations, and ongoing systems development.

Importance of Collaboration

Because of the chronic and relapsing nature of substance abuse disorders, ensuring a child's ongoing safety in a home with a substance abuser, or working toward reunification of a family in that home, can be extremely difficult.

Even when the parent seeks help or is ordered by the court to seek help, the parent's treatment needs and the family functioning issues related to child safety are rarely addressed simultaneously (CWLA, 1992; Young et al., 1998). The intertwined problems of substance abuse disorder and child abuse require that systems collaborate if they are to break the intergenerational cycle that has resulted in so much damage to society. However, historically, there have been barriers to such collaboration.

Different perspectives on dependency

Alcohol and drug counselors and CPS workers are both involved with clients with substance abuse disorders, but generally their perspectives on addiction are quite different (see DHHS, 1999). This difference is at the heart of the conflicts that historically have characterized relationships between these two groups of professionals and prevented closer cooperation. Much of the substance abuse treatment community views the alcohol- or drug-using parent who neglects or abuses a child as having a chronic and often progressive disease that cannot be cured but can be treated. However, much of the rest of society, including some CPS workers and judges, view this parent as having made an irresponsible choice that has endangered a child. In addition, the CPS worker may perceive the counselor as willing to overlook unsafe situations for children to avoid alienating the parent and disrupting treatment. The treatment provider, however, may see the CPS agency worker as unwilling to give the parent's treatment a chance to work.

Different clients, different goals

Another barrier to collaboration between the two fields is that the organizations have different clients and different goals. Although the CPS agency worker will seek to ensure the child's safety, the alcohol and drug counselor is focused on treating the parent.

Different timeframes

For the treatment provider, relapse is an expected part of recovery from a condition that has taken years to develop and will take years to resolve. CPS agency workers and the courts are accustomed to working within shorter and more well-defined time frames (usually 18 months) because of their desire to prevent children from remaining for long periods in out-of-home placements and to ensure that permanency plans are made for the child.

A related factor is the overburdened public system and the frustration that professionals in both fields often experience, not only within their own agencies but also in dealing with other systems. For example, CPS agency workers who refer parents to a substance abuse treatment program often find that the program has a long waiting list and that no help is immediately available. Similarly, alcohol and drug counselors who report suspected child maltreatment often complain that their reports go unheeded or are dismissed for lack of evidence in a system where workers have time to focus attention on only the most egregious cases (Reid et al., 1999).

Improving collaboration

Treatment providers and CPS agencies differ in their priorities and approaches to parents with substance abuse disorders. To improve their working relationship, these agencies do not need to lessen their commitments to their different missions; instead, they must recognize that both sets of goals are compatible and can best be achieved through joint efforts (Feig, 1998).

6 Legal Responsibilities and Recourse

Because many parents who abuse substances also neglect or abuse their children, it is common for clients in substance abuse treatment to have contact with some part of the child protective services (CPS) system. While the organizational roles and titles will vary, a CPS agency is the part of a State's child welfare system responsible for investigating and processing child abuse and neglect cases. For convenience, the term "CPS agencies" is used in this chapter to refer to all aspects of social services related to child welfare. For more on the role of CPS agencies, see Chapter 5.

Some substance-abusing parents will be drawn into the CPS system during treatment; others will be compelled into substance abuse treatment by a CPS agency. In either case, it is critical that treatment providers become familiar with the laws governing the child protective system, including

- How child abuse and neglect are defined
- Whether, when, and how a counselor must report a parent or other primary caretaker—or a parent who was maltreated in childhood—to a CPS agency or police
- What happens after a report is made
- How State-mandated family preservation services operate
- How welfare reform will affect clients in treatment

There are a number of Federal and State laws designed to protect the health and safety of children:

- State criminal statutes outlawing certain acts
- State civil statutes prohibiting child abuse and neglect
- State mandatory reporting laws requiring certain categories of persons to report suspected child abuse or neglect
- State "family preservation" laws offering families certain services or requiring families to participate in substance abuse treatment or types of counseling
- State "fast track" adoption laws that limit the time a child may remain in foster care before the State brings proceedings to terminate parental rights and free the child for adoption
- Federal laws requiring States to adopt policies, goals, and time limits in the child welfare realm

Complicating the picture are the Federal law and regulations governing confidentiality of information about clients in substance abuse treatment (42 U.S.C. §290dd-2; 42 Code of Federal Regulations [C.F.R.], Part 2), which restrict the circumstances under which programs can make disclosures about clients, as well as the information they can disclose. This chapter explains the legal requirements treatment providers must follow, discusses the difficulties and potential conflicts that may arise, and offers some guidelines to help minimize legal difficulties and clinical dilemmas.

Mandated Reporting

All States require designated groups of individuals to report incidents of known or suspected child abuse or neglect. Eighteen States, in fact, require all citizens to report suspected abuse or neglect; other State mandatory reporting statutes often include substance abuse treatment staff, particularly staff comprised of State-licensed therapists, nurses, and social workers. If a professional's failure to report results in injury to the child, he may face criminal charges or a civil suit for damages or suspension or revocation of his professional license. Those who are mandated reporters under State law generally are immune from liability for reports made in good faith that are later found unsubstantiated or erroneous. In some States, any person or agency that employs individuals who are mandated reporters must provide all employees with written information outlining the reporting requirements.

An adult survivor of abuse, however, usually discusses events that took place many years before. In these situations, there is generally not a duty to report and often little legal recourse for the survivor. A counselor is generally under no obligation to report abuse or neglect that the client describes suffering as a child many years ago. CPS agencies are not interested in investigating cases in which no child is in imminent danger. However, if the person who abused or neglected the client now has custody of other children, the program should seek advice about whether it has reporting responsibility. If a client consents, the program can report the situation even if it is not mandated to do so. The situation is more complicated if, while in treatment, a client has had to leave her children with a family member who is the same person who abused her as a child. She may fear for her children's safety but have no alternatives for child care and therefore may not even identify this person as the perpetrator.

Mandatory Reporting Procedures

All States specify how reports must be made. Most require an immediate oral (spoken) report, and many now have toll-free telephone numbers to facilitate reporting. Most States require that reports include

- The age and address of the child
- The address and name of the parent or caretaker
- The type of abuse or neglect, as specific and factual as possible
- The name of the perpetrator

Most States require oral reports to be confirmed in writing and within a given time frame. State statutory reporting procedures are available on the Internet at http://www.calib com/nccanch/services/statutes.html.

Disclosing information in reporting child abuse or neglect

Substance abuse treatment providers should disclose only the information required by State law when they report child abuse or neglect. Counselors and other staff members in treatment agencies are permitted to comply with State mandatory reporting laws under a narrow exception in the Federal confidentiality regulations. Those regulations (which are discussed below and in Appendix B) generally prohibit substance abuse treatment agencies and their staff from disclosing client-identifying information to anyone without the client's written consent. The child abuse reporting exception *applies only to initial reports of child abuse or neglect* (42 C.F.R. §2.12 (c)(6)). Programs *may not* respond to followup requests for information or to subpoenas for additional information, even if the records are sought for use in civil or criminal proceedings resulting from the program's initial report. (See below for a discussion of how to deal with such requests.) That means that in making an initial report of suspected abuse to a CPS or other designated agency, the mandated reporter should provide only the basic information required by the State mandatory reporting law. The counselor may give her name and the name of the program, and if the law requires it, she must. No other information should be disclosed without the client's written consent.

Please note that these guidelines are an explanation of current Federal and State laws regarding client confidentiality for substance abuse treatment programs. They are meant to help reduce legal complications that could interfere with a client's treatment—or a program's operation. They are not meant to imply or encourage an adversarial relationship with CPS agencies. Ongoing collaboration is important and allowed *when appropriate consent forms are signed*. With more than 50 percent of child protective cases involving substance abuse, CPS agencies are dependent on the expertise of the treatment agencies.

Dealing with the legal requirements: Making the task easier

Agencies providing substance abuse treatment should develop a protocol to handle legal requirements. For example, an agency may have a protocol that requires the counselor to discuss the case in question with a supervisor. If they decide the case is reportable, then the supervisor discusses it with the clinical director. If more information is sought, such as by subpoena, the director would contact a lawyer. Orientation for new staff members should include the agency's reporting policies and procedures. It is recommended that these policies include provisions requiring staff members to inform their supervisor or appropriate program personnel whenever they make a report, as well as the need to consult with their supervisor whenever they have concerns regarding the need to report.

Many substance abuse treatment agencies have found it useful to designate a capable member of the staff to

- Handle all requests for information from outside individuals or organizations when no proper consent form exists to authorize a release of information
- Keep current with developments in the area of child abuse and neglect, including court decisions that clarify what conditions are reportable and how reports should be made
- Develop and update a list of resources the agency can consult when difficult questions arise (e.g., there may be a member of the agency's governing board who is a lawyer who would be willing to provide advice in difficult cases)
- Develop a form to use in making reports so only specific, relevant information is given
- Be careful of letterheads, logos, and headings on fax machines that may inadvertently reveal that the treatment center is involved

A list of other potential sources of assistance appears in Figure 6-1.

Clinical concerns

Counselors may be concerned that compliance with the mandatory reporting law will damage the client–counselor relationship or trigger relapse. A recent study shows that neither is likely to occur: Most clients stay in treatment after a report, and many are able to overcome the negative feelings that often result (Steinberg et al., 1997).

There are ways to limit the potential damage to the therapeutic relationship. The first is to inform the client about the mandatory reporting law at the time of admission (Watson and Levine, 1989). This practice is actually required by the Federal confidentiality regulations. §2.22 of the regulations requires that substance abuse

Figure 6-1

Reporting Child Abuse and Neglect: Sources of Advice in Difficult Cases

Sources to be consulted only after reviewing confidentiality rules

- A clinical supervisor or a member of the treatment team
- Another peer
- The treatment program's legal counsel (or an attorney who is a board member)
- The CPS agency (speak of a "hypothetical" case)
- Counsel for the Single State Agency
- The State Attorney General's office
- The local legal aid society or legal services office
- An attorney at a family law clinic or, perhaps, at a law school
- An attorney in private practice who specializes in family law
- The local bar association
- Professional organizations such as the American Psychological Association and the National Association of Social Workers*
- Child Welfare League of America*
- Resource Center on Domestic Violence: Child Protection and Custody*
- Childhelp USA/National Child Abuse Hotline*

* These resources may be unable to give case-specific advice because of the differences in State laws.

treatment programs give all clients a notice describing the confidentiality rules, as well as their exceptions (which include mandatory child abuse reporting), upon admission or as soon thereafter as possible. (The regulations contain a sample notice at §2.22(d) that may be used for this purpose.) This practice is also endorsed by the American Psychological Association and the Code of Ethics for Social Workers (Kalichman, 1993).

A second way to limit damage is to provide the client an opportunity to self-report. Self-reporting "affords the individual an opportunity to assume responsibility for his or her own actions and allows for at least some control in what otherwise might be a powerless situation" (Kalichman, 1993, p. 126). If the client makes the report from the counselor's office, the counselor can provide appropriate support. Counselors should be aware, however, that although this might preserve the therapeutic relationship, it may not fulfill the counselor's statutorily imposed duty to make a report. Sometimes it is possible to minimize damage to the relationship by completing the report (both oral and written) in the client's presence.

If there is imminent risk to a child, the counselor may not have time to engage the parent in the process. For example, if a counselor learns that the client has scalded his child and tied him to the bed, it would be appropriate to contact a CPS agency immediately. Similarly, if there is a risk that the client will continue his behavior and seek to cover his tracks, the counselor would probably not involve him in the report or inform him until after it has been made.

Although counselors may sometimes be tempted to use the threat of reports to coerce clients into complying with treatment requirements, counselors must remember that the purpose of the reporting laws is to protect children—*not* to provide counselors with a bargaining chip in the treatment process.

Reporting may advance a client's recovery by providing an appropriate limit-setting example, increasing the parent's sense of responsibility for harmful behavior, and giving the family an opportunity to change. Parents may be relieved after a report has been made that external control has been introduced into a situation that frightens them as much as it does the children. Reporting may also open a dialog with the client concerning family relationships and any personal history of abuse, if one exists. Whether these positive results occur appears to depend on when the report is made (earlier in treatment is more likely to affect the relationship negatively), how much support the counselor offers when the report is made, and how well the counselor deals with the client's anxiety and anger (Melton et al., 1995).

The National Center on Child Abuse and Neglect offers the following guidance:

> The law does not require mandated reporters to tell the parents that a report is being made; however, in the majority of cases, advising the client is therapeutically advisable. First, the therapist is employing clinical leverage by using authority to set a firm and necessary limit.... Second, if the therapist does not mention the report, there is secrecy and tension, which may result in the clients' feelings of suspicion, isolation, or betrayal. In some cases, reporting may elicit an extreme response from the clients.... It can be very beneficial to give clients the opportunity to make the reports themselves in the therapist's presence (Peterson and Urquiza, 1993, p. 13).

Although the manner in which the counselor makes the report may affect the counselor–client relationship, the importance of that relationship must not override the counselor's responsibility to fulfill the statutorily imposed obligation to report when a report is necessary to protect a child. If a client has a history of violence, the counselor must also consider her own safety when deciding how much to include the client in the reporting process.

Developing Reporting Policies And Procedures

Failure to comply with statutory reporting mandates or to limit the report as required by the Federal confidentiality regulations can place the individual counselor and the counseling agency at risk. Therefore, everyone in the agency who is required by law to report suspected abuse or neglect must clearly understand when and how a report must be made and what information must be reported.

The best practice is to adopt a written policy or protocol before a case arises. Recently hired counselors should read or be given training on such policies. Reporting policies and procedures should include a reference to the State's legal requirements, including the definitions of child abuse and neglect, the categories of persons who must report, what information must be in the report, and how a report should be made and documented. Specifically, the Consensus Panel recommends that agency policy include

- A statement that the agency strictly adheres to the State's mandatory reporting laws
- The State's definition of abuse and neglect
- The State law delineating when reports must be made (e.g., when a counselor has "reasonable suspicion" or "reasonable belief")
- A list of the categories of persons who are mandated reporters
- An outline of the information that must be reported and a statement that no other information will be disclosed unless the client has consented in writing
- The name, address, and telephone number of the person or agency to whom the report must be made (Generally, jurisdictions require persons who suspect child abuse or neglect to telephone a report to the local CPS

agency or the department of human services and follow it with written confirmation.)

- A requirement that clients receive a notice, when they are admitted, summarizing the Federal confidentiality regulations and the child abuse reporting exception (§2.22(a)) (The Federal regulations contain a sample notice that may be used for this purpose; the Consensus Panel recommends that the client be required to acknowledge in writing receipt of the notice.)
- A requirement that staff members who are mandated reporters consult a supervisor or team leader before calling the CPS agency to report suspected child abuse or neglect unless the situation is an emergency (Some States require that the agency as well as the individual care provider make a report; moreover, consulting with a supervisor ensures that the wisest decision is made in this emotionally charged area, particularly in ambiguous or doubtful cases, and it will ensure that the agency is prepared to handle any legal issues that may subsequently arise.)
- A statement describing how the report must be documented in the agency's records (At a minimum, documentation should include the name of person and agency to whom a telephone call was made, the date and time of the call, the information provided, a copy of the written confirmation, and a notation of whether and when the parent was notified of the report.)
- Guidelines describing when and how the client will be notified, including a description of the circumstances under which a parent should not be notified because of danger to the child
- A procedure for review of all cases and of issues that arise after reporting (Routine review will ensure that any problems, whether of a procedural or therapeutic nature, will be addressed expeditiously.)
- A requirement that orientation for all new staff include the agency's reporting policies and procedures and a statement that the agency will provide ongoing training in this area

State Laws Regarding Child Abuse and Neglect

All 50 States and the District of Columbia have statutes that protect children from abuse and neglect by their parents or others. There are criminal statutes prohibiting certain acts (or failures to act), violation of which may lead to imprisonment. There are also civil statutes that prohibit abuse and neglect. If these statutes are violated, the court may impose requirements that parents accept certain kinds of help (such as substance abuse treatment, parenting classes, or anger management training), that their children be removed from the home, or that their parental rights be terminated.

Most States define abuse as an act or failure to act that results in nonaccidental physical injury or sexual abuse of a child. Neglect generally includes the denial of adequate food, shelter, supervision, clothing, or medical care when such resources or services are available. As noted in Chapter 1, each State defines abuse and neglect differently, and the conditions considered to be neglect or abuse in one State may not be the same in others. Because State law often requires that treatment providers report suspected abuse and neglect, treatment staff should become familiar with their State's definitions of abuse and neglect. Staff can contact the State's CPS agency for information on current laws. (If the abuse occurred in another State, or if the perpetrator is currently living in another State, it is wise to check on the laws in the other State to ensure compliance. At times, there may be a need to report in both States.) Readers can also find State statutory child abuse and neglect definitions on the Internet at http://www.calib.com/nccanch/services/statutes.htm. Federal definitions of these terms appear in the Child Abuse Prevention and Treatment Act, 42 U.S.C. §5106(g). In some cases, the CPS agency can be consulted regarding whether or not a report must be made in a particular situation without divulging confidential (i.e., identifying) information. Consultation with the CPS agency must be done with great care, and this communication can be noted in the client's chart.

Although each State's laws are different, the following conditions are reportable in most States:

- The child has been seriously physically injured by a parent or other adult by other than accidental means.
- The child appears injured or ill to the point that a reasonable person would seek medical attention, but the parent has not sought medical attention, refuses to consider it, or fails to follow medical advice, putting the child at risk.
- An adult has sexually touched (or made the child sexually touch the adult), abused, or exploited the child.
- The child is not registered for or attending school, and the parent refuses to remedy the situation (home schooling must be adequately documented).

Although the behaviors outlined above are the most blatant examples of child abuse or neglect, other parental behaviors or practices may put children at risk. For example, the following may also constitute child abuse or neglect:

- Leaving a young child alone and unsupervised
- Inappropriate punishment that puts a child at risk (e.g., locking a young child out of the house as a punishment)
- Depriving a young child of food for an extended period of time
- Treating one child, the "bad one," far more harshly than others

Whether behaviors like these are reportable depends, in part, on how State statutes define abuse and neglect, the seriousness of the behavior or incident, its impact on the child, and the counselor's perception of the client's overall behavior with the child and of the client's willingness to correct inappropriate behavior.

The difficulty for counselors is that substance abusers are often the products of poor parenting themselves and many have had little or no exposure to appropriate parenting behavior (Whitfield, 1981). Without a reasonable model of nurturing behavior, they may simply deal with their children in the same inappropriate ways they were treated. They may have no intention of harming their children and no notion that they are putting their children at risk.

Because of these complicating factors, the decision whether to report parents who treat their children inappropriately can be rather difficult. Clearly, inappropriate child-rearing practices cannot be ignored; they are important danger signals. Yet not every inappropriate action a parent takes can—or should—be reported. On the other hand, counselors must keep in mind that they are required to report when they have a firm belief or a reasonable suspicion (the statutory definition will vary) that a child is abused or neglected (as that term is defined). Their responsibility is limited to making a report; it does not include conducting an investigation to determine whether the abuse or neglect actually occurred. That is the job of the CPS agency. There may also be timeframes within which reporting must occur, and sanctions for failure to report.

If counselors are unsure of how to proceed or what is required in a murky or complex case, they should consult with a supervisor, a colleague in the treatment program, or others (see Figure 6-1, above). Of course, such consultation must be made without violating Federal confidentiality regulations. (See Appendix B for a further discussion of this issue.) As this chapter advises earlier in "Developing Reporting Policies and Procedures," programs should adopt written policies governing child abuse reporting and should require counselors to consult with supervisors before making a child abuse or neglect report. Ongoing training and a thorough knowledge of community resources will help counselors determine what actions are most likely to benefit the child and whether reporting is required.

Parental Substance Abuse as Child Abuse and Neglect

The differences in the ways States define child abuse and neglect are particularly striking in the area of parental substance abuse. In some States, parental substance abuse, by itself, may constitute child abuse or neglect. In others, something more must be shown. For example, in South Carolina, giving birth to a drug-exposed infant is a criminal offense; a conviction may send the mother to prison (*State* v. *Whitner*, 328 S.C. 1, 492; S.E. 2d 777 [1997], *cert. denied*, 118 S. Ct. 1857 [1998]). In other States, like New York, "[a] report which shows only a positive toxicology for a controlled substance [in the newborn] generally does not in and of itself prove that a child has been [neglected]" (*Nassau County Department of Social Services* v. *Denise J.*, 87 N.Y. 2d 73, 661 N.E. 2d 138, 637 NYS 2d 666 [1995]).

New York offers a particularly interesting approach to the question of parental substance abuse, as it distinguishes among three kinds: (1) those parents who misuse substances but not to the extent that they become intoxicated, unconscious, or their judgment is impaired; (2) those parents who misuse substances but are in treatment; and (3) those parents not in treatment who misuse substances to the extent that they become intoxicated, unconscious, or their judgment is impaired.

In New York, a CPS agency that brings a neglect proceeding against a parent who uses substances must show, at a minimum, that the parent "repeatedly misuses a drug or drugs or alcoholic beverages, to the extent that it has or would ordinarily have the effect of producing a substantial state of stupor, unconsciousness, intoxication, hallucination, disorientation or incompetence, or a substantial impairment of judgment or a substantial manifestation of irrationality...." Substance abuse below that level is not prima facie evidence of neglect. When a parent is in treatment, the State may not use "such drug or alcoholic beverage misuse [as] *prima facie* evidence of neglect" even if it results in "a substantial state of stupor" (§1046(b)(iii) of the Family Court Act).

Similarly, for a court to rule that a child is neglected because of the substance abuse of a parent who is not in treatment, the court need find only that the parent's substance abuse results in loss of self-control of his actions. On the other hand, if the parent is voluntarily and regularly participating in treatment, the court cannot make a ruling of neglect unless it finds (1) that the substance abuse results in the loss of self-control and (2) that there is sufficient evidence that the "child's physical, mental or emotional condition has been impaired or is in imminent danger of becoming impaired" (§1012(f) of the Family Court Act).

The wide variation in the way States define child abuse and neglect makes it imperative that providers be familiar with their States' statutes.

Substance-using pregnant women

Many States have employed both criminal and civil sanctions in an attempt to penalize pregnant women who use substances for the harm they may be causing the fetus. Since until recently no existing criminal statute directly addressed prenatal injury to the fetus by a substance-using mother, criminal prosecutors have used "State statutes related to child abuse and neglect, involuntary manslaughter, prohibitions on delivery or distribution of controlled substances to minor, and pure drug use" (Garrity-Rokous, 1994, p. 219). By 1991, at least 19 States and the District of Columbia charged women with felonies for substance use during pregnancy.

Many courts have also disregarded sentencing guidelines and imprisoned pregnant drug users for terms long enough to ensure their infants were born drug free (Garrity-Rokous, 1994). The South Carolina State Supreme Court was the first to rule that a viable fetus could be considered a "person" under child abuse laws. (In other States, however, courts have held that child endangerment laws do not apply to fetuses.) In South Carolina, district attorneys were directed to treat situations in which a pregnant woman is using drugs as subject to duty-to-report provisions, placing medical personnel and counselors in legal jeopardy if they failed to inform authorities of such a pregnancy. In a related trend, judges commonly remand substance-using pregnant women who are arrested for prostitution, drug peddling, or other crimes to residential treatment centers, which are ordinarily reserved for persons with severe substance dependence.

Mothers who give birth to babies who are born harmed by or addicted to illegal substances may also face legal consequences. Child abuse and neglect laws have been passed in some States specifying that the birth of an infant who is addicted to an illegal substance constitutes a mandated reporting situation. A South Carolina woman was sentenced to a 5-year prison term for child neglect when her child was born with cocaine in his system. In a well-known 1989 Florida case, another woman was arrested and mandated into residential treatment for child abuse because of evidence of cocaine in the umbilical cord at birth. Because a fetus is not considered a "person" in Florida, the State prosecutor had to show that the woman "delivered drugs" to the baby in the brief period before the umbilical cord was cut (Garrity-Rokous, 1994). Eventually, the Florida Supreme Court overturned this conviction. Even so, there has been a movement in some States to define any maternal substance use during pregnancy as child abuse or neglect.

Significant cultural and economic issues are associated with the way in which State reporting requirements are implemented. One landmark study showed that a woman who delivers a substance-dependent child is more likely to be reported if she is a woman of color (Chasnoff et al., 1990). It is worth noting that the same standards are not applied to women who use alcohol or smoke, even though the consequences may be equally—or even more—harmful for the baby. The long-term impact of fetal alcohol syndrome is far more clearly documented than that of fetal exposure to cocaine, for example. And according to at least one study, maternal alcohol abuse may be the most frequent environmental cause of mental retardation in the Western world (Ray and Ksir, 1996).

If counselors are aware of these trends in their jurisdiction, they will be better able to discuss the possible legal consequences with pregnant women. At the same time, understanding the current mood in the country will allow the counselor to understand better the added stress felt by drug-abusing mothers. This pressure is a good topic to discuss with pregnant clients in substance abuse treatment. Counselors should be aware that the client's concern for her unborn child, and the self-esteem issues evoked by the situation, might help keep her in treatment—or lead to relapse.

CPS Agency Investigation And Potential Outcomes

Once a professional, relative, or neighbor has made a report about a child, the State or local CPS agency is supposed to take action and investigate the complaint. If the complaint is unfounded or unsubstantiated, it is dismissed, and there are no further consequences. If, on the other hand, an initial investigation substantiates the complaint, the CPS agency has a number of options:

1. It may reach an agreement with the family (without filing any court action) regarding what changes are needed and what services will help the family achieve those changes. It will then develop a service plan outlining the remedial steps the family has agreed to take and establishing a timetable for the family to complete those steps.
2. A CPS agency can bring a neglect or abuse petition against the parent or guardian in a family or trial-level court. After a trial or fact-finding hearing, the court may take one of the following actions:
    a. Dismiss the petition (setting the parent free from further obligation)
    b. Issue an order requiring the parent to comply with all or part of the CPS agency's service plan, an order the court may review periodically to assess the parent's compliance (If the parent fails to comply with the court's order, the court may, after a hearing, either give the parent another chance or, if the case has been pending for some time, the parent has made little progress, or her behavior is particularly egregious, remove the child and begin proceedings to terminate parental rights.)
    c. Issue an order for the child's removal
3. If the situation is life threatening, a CPS agency can remove the child (and any siblings) immediately and schedule a prompt court hearing at which the parent or guardian may contest the removal. If the court finds the removal unnecessary, the child may be returned, but the parent may still be required to comply with a service plan.
4. A CPS agency can refer the case to criminal justice officials.

The majority of child abuse or neglect reports will not result in full-fledged court cases. Of those that do result in court action, most are brought in a family court, where hearings are closed to the public and files are sealed. Only rarely will a report result in criminal charges against the parent.

Whatever is reported to the CPS agency or whatever action that agency takes, if the parent contests the charges or objects to the CPS agency's proposals, she is entitled to a hearing and to be represented by an attorney. In this country, parents may not have their children permanently removed or their parental rights terminated or be punished or be required to go into substance abuse treatment without a court proceeding. (Of course, parents may find themselves coerced into agreeing to enter treatment to retain their children.) In cases where a child has been removed from a home against the parent's wishes, a hearing must be held within a specified time, or the child must be returned. The focus in any initial hearing will be placement of the child during a CPS agency investigation or during any trial.

The Service Plan

Unless the charges of child abuse or neglect are dismissed (or the parent is charged with a crime and incarcerated), at some point the CPS agency will meet with the client to assess his needs and develop a service plan.

The plan should detail

- The steps the client must take and the terms and conditions he must meet to retain or regain custody of the children
- A timetable for accomplishment of each step, term, and condition
- A list of resources the CPS agency will make available to the family

It is the CPS agency's obligation to make every effort to assist the client in retaining or regaining custody of his children.

Clinical Issues

The counselor's role can be critical for a client involved in a child abuse or neglect investigation or proceeding. Getting the client to sign a consent form allowing communication and joint service planning can be an important first step (see Appendix B). The counselor can help a client understand what is happening, help her stay focused on what needs to be accomplished, and provide support and encouragement. However, to offer the client sound assistance the counselor needs some basic information:

- Is this the first time the client has had a case with a CPS agency?
- What are the charges against the client (e.g., abuse, neglect)? What precisely is the client charged with doing or not doing?
- Has a child ever been removed from the client's home?
- Does the client have a lawyer representing him? (The counselor should ask the client to sign a consent form permitting the counselor to communicate with the lawyer.)
- At what stage is the client's case? Has the client agreed to a service plan? Is he subject to a court order?
- What actions must the client take to comply with the service plan or court order? Is there a timetable?
- What are the likely outcomes of the proceeding and is termination of parental rights a possibility?
- What is the client's view of the CPS agency and of the entire situation?

Although some might think the last question strange, soliciting the client's view of the CPS agency will help to maintain the counselor–client relationship as the investigation unfolds. Clients have often had negative experiences with CPS agencies or other social service agencies that have intervened in their lives, especially if cross-cultural issues are involved. If a counselor acts on the assumption that the client thinks a CPS agency is acting in her best interest, the counselor may well alienate the client and close the door on what could be an opportunity for developing a therapeutic alliance. In other words, if the counselor characterizes the CPS agency's intentions as beneficent and its intervention as beneficial, the client may well view the counselor as naive at best, and possibly part of the "enemy camp." It is best to begin a dialog with the client about the role of the CPS organization. Perhaps the safest approach is for the counselor to take the position that whether or not the CPS agency's intentions are benign or its intervention is welcome, it is a force with which the client must deal.

It is important, however, for the counselor to help the client move past denial, hurt, and anger into a working relationship with the CPS agency. She should not align or overidentify with the client against the CPS agency. The counselor should make it clear that his major role in this situation will be to work with the client to ensure that the client understands and complies with the CPS agency's or the court's requirements regarding substance abuse treatment. To this end, the counselor should obtain a copy of the service plan and review it with the client. The terms and requirements of the service plan can often be integrated effectively into counseling objectives.

In fact, the CPS system may have information for the treatment provider on the client's substance abuse history and other relevant clinical information. Collateral information from CPS agencies on substance abuse evaluations can be invaluable in raising the quality of the evaluation, providing accurate information, and making better treatment decisions. (For guidelines on maintaining client confidentiality and the legal requirements involved, please see Appendix B.) Frequently clients do not understand the severity of their situation and may minimize or withhold information. This may be due to drug-related cognitive impairments, low IQ, naivete regarding the legal system, or the same denial and rationalization that sustained their addictions.

Service plans may include a comprehensive treatment plan involving several agencies. Some communities have established multiagency teams to coordinate support for families in crisis. In West Hawaii, for example, a multidisciplinary team is formed to assist the CPS agency worker in high-risk or complex cases, such as severe abuse that results in hospitalization. Members of the team represent the disciplines of medicine, nursing, psychology, and social work. Because more than half of reported child abuse and neglect cases involve substance abuse, a substance abuse treatment professional has recently been added to the team. The team helps the CPS agency worker assess the extent to which further harm is likely to befall the child, gauge the family's motivation and capacity for change, and weigh the advisability of various options for protecting the child. Team members review available documentation (such as case histories, school reports, and medical records) in addition to contributing their own knowledge of the family in question, providing a wide range of additional support on an as-needed basis. Pediatricians assess the medical needs and perform comprehensive abuse, neglect, and sexual abuse exams. Consultants also provide expert witness testimony for the family court.

The team approach can be extremely helpful to a client or family involved in the child protective process. The team can coordinate services so that requirements, appointments, and obligations do not overwhelm the client and can reduce the number of conflicting demands the client must meet. A team approach can be very helpful in obtaining a more complete picture of the client and the severity of the problem. A client often presents differently to various practitioners and may share different information depending on the practitioner's area of expertise and nature of the relationship with the client. The difficulty for a treatment provider is that before information may be shared with other agencies, the client must sign a consent form permitting the program to communicate freely with specified agencies. (In parallel fashion, the client must have signed a consent form allowing the other agency to communicate with the substance abuse treatment provider. Some counselors address this by having the client sign the two consent forms necessary for two-way communication and sending a copy of the appropriate version to the other agency.) The other agencies must also understand that they are prohibited by Federal regulations from redisclosing any information they receive from the counselor (see Appendix B).

Communicating With CPS Agencies And Others After the Initial Report

Alcohol and drug counselors working with parents during CPS agency investigations or court proceedings may find that the CPS agency and others view them as a good source of information. It is important to keep two things in mind. First, substance abuse treatment programs and the child welfare system (including both the courts and the CPS agency) have different concerns, goals, and measures of success. Once the counselor has made the initial report, her concern must turn to the client's progress toward recovery. While the child protective system is also concerned with the client's recovery, its focus is on the child's safety and stability. These differences in primary focus mean that while the alcohol and drug counselor can help the client achieve recovery (and thereby successfully end the involvement of the CPS agency), she cannot change either the client or the situation. Sometimes, the treatment system's interest in the client's recovery conflicts with the CPS agency's interest in protection of and permanency planning for the child. For example, the counselor's goal of having the client reduce his substance abuse (and allowing sufficient time for that to happen) may conflict with the CPS agency's goal of finding a permanent placement for a child who has been in foster care for many months.

Counselors must keep in mind that they may communicate with or respond to requests for information only when the proposed communication conforms to one of the Federal regulations' narrow exceptions permitting a disclosure. If a counselor fails to abide by Federal confidentiality rules, an unpleasant and expensive lawsuit may be brought against the program and possibly the counselor. Moreover, if word spreads that the program fails to protect information about its clients, it may have a difficult time in retaining its clients' confidence and in attracting new clients into its treatment services (as well as the possibility of professional sanctions and relicensing difficulties).

The following discussion about communicating with parts of the child welfare and legal systems relies heavily on four exceptions to the Federal regulations that permit disclosures:

- Proper written consent from the client (§2.31)
- Proper written criminal justice system consent from the client (§2.35)
- Court orders (§§2.64–2.66)
- Qualified service organization agreements (§§2.11, 2.129(c)4))

Appendix B contains a full discussion of the regulations, including these exceptions.

Dealing With CPS Agencies, Courts, And Law Enforcement

All professionals who work in the field of substance abuse treatment are aware that their clients have serious problems that may involve procuring and using illicit drugs. Abuse of such illicit substances interferes with their lawful behavior and, when they are parents, interferes with responsible parenting (Magura and Laudet, 1996). Treatment providers, therefore, will often need to interact with the legal and child protective systems. The way in which counselors interact with these agencies will vary from case to case. The counselor may have to contact a CPS agency to report a client suspected of child abuse, or the legal system may contact the counselor for information about a client's participation in a treatment program. Whatever the nature of the interaction with CPS agencies or the legal system, counselors need to be aware of their legal responsibilities.

The following subsections discuss how the counselor should deal with various agencies. In all of these circumstances, the Consensus Panel recommends that counselors (1) ask for their supervisor's guidance on what boundaries to keep, (2) consult their client, (3) use common sense, and (4) consult State law (or a lawyer familiar with State law).

Communicating with a CPS agency

Even if a CPS agency has sent the program a Request for Information Release that the client has already signed, if the form does not comply with §2.31 of the Federal confidentiality regulations, the counselor may not release any information. (For a sample form that complies with the Federal regulations, see Appendix B.) Even if the form complies with the Federal requirements, the counselor should remember that a signed consent form does not require her to disclose any information. The counselor should still evaluate the appropriateness of the request in the context of its impact on the client's treatment.

First, after getting the client's written consent to do so, the counselor should consult with the client's lawyer. (Some clients may not be aware that they have the right to an attorney when custody of their children is being questioned.) The counselor should ask the lawyer whether she has objections to the program's making a disclosure and whether she thinks it is in the client's interest for the program to disclose the requested information. The lawyer may be pleased to know that the Federal confidentiality regulations provide a way to limit the kind of information disclosed. If the lawyer has no objections, the counselor can simply have the client sign a valid consent form, making sure to limit the scope of the disclosure as appropriate (and as the regulations require). If the lawyer does have an objection, then it is best to let her take the lead.

If the client has signed a proper consent form authorizing the counselor to communicate with the caseworker at the CPS agency, how much information should the counselor disclose and how active a role should he take? In some cases, disclosing information to the CPS agency or court will benefit the client. It may also help the client if the counselor participates in developing a service plan for the family. However, it is up to the client and the lawyer, not the counselor, to determine whether communication or cooperation with a CPS agency will benefit the client. Therefore, it is essential that the counselor communicate with the client's attorney *before* taking it upon himself to communicate with a CPS agency.

Counselors should avoid using a standard report form in communicating with a CPS agency, unless the form calls for a limited amount of relevant, objective data. Each case is different, and a one-size-fits-all approach may hurt the client. It is best to think through each case on its own terms—with the help of the client's lawyer and with appropriate supervision. Sometimes, however, CPS agencies only need to know whether the client is participating in treatment, what the program's expectations are, if the client's participation has been satisfactory, the extent of drug involvement, and whether the client has complied with specific directives the treatment provider may have made.

Responding to lawyers' inquiries

If a lawyer calls to find out about a client's treatment history or current treatment, unless the client has consented in writing to the counselor's communicating with the lawyer, the counselor must tell the lawyer, "I'm sorry. I can't respond to that question right now. Can I have your telephone number and call you back at another time?" This is because the Federal confidentiality regulations prohibit any other response without the client's written consent. The regulations view any response indicating that the person in question is the counselor's client as a disclosure that the person is in fact in substance abuse treatment. This applies even if the lawyer already knows that the client is in treatment.

A firm but polite tone is best. If confronted by what could be characterized as "stonewalling," a lawyer may be tempted to subpoena the requested information and more. The counselor will not want to provoke the lawyer into taking action that will harm the client. Even if the counselor has the client's written consent to speak with the lawyer, she may find it helpful to consult with the client before having a conversation about him. The lawyer can be told, "I'm sure you understand that I am professionally obligated to speak with this person before I speak with you." It will be hard for any lawyer to disagree with this statement.

The counselor should then speak with the client to ask whether the client knows what information the caller is seeking and whether the client wants her to disclose that or any other information. She should leave the conversation with a clear understanding of the client's instructions—whether she should disclose the information and, if so, how much and what kind. It may be that the lawyer is representing the client and the client wants the counselor to share all the information she has. On the other hand, the lawyer may represent the CPS agency, the prosecuting attorney, or some other party with whom the client is not anxious to share information. There is nothing wrong with refusing to answer a lawyer's questions.

If the lawyer represents the client and the client asks the counselor to share all information, the counselor can speak freely with the lawyer once the client signs a proper consent form. However, if the counselor is answering the questions from a lawyer who does *not* represent the client (but the client has consented in writing to the disclosure of *some* information), the counselor should listen carefully to each question, choose her words with care, limit each answer to the question asked, and take care not to volunteer information not called for. If the lawyer asking for information represents the prosecuting attorney, the counselor should consult both the client and his lawyer, as well as the program's legal counsel before responding to any questions.

Responding to subpoenas

Subpoenas come in two forms. One is an order requiring a person to testify, either at a deposition out of court or at a trial. The other—known as a *subpoena duces tecum*—requires a person to appear with the records listed in the subpoena. (Depending on the State, a subpoena can be signed by a judge or filled out by a lawyer and stamped by a court clerk.) Unfortunately, it can neither be ignored nor automatically obeyed.

When a subpoena is received, the counselor should call the client about whom he is asked to testify or whose records are sought and ask what the subpoena is about. It may be that the subpoena has been issued by or on behalf of the client's lawyer, with her consent. However, it is equally possible that the subpoena has been issued by or on behalf of the CPS agency's lawyer (or the lawyer for another adverse party). If that is the case, the counselor's best option is to consult with the client's lawyer (if the client has signed a consent form) to find out whether the lawyer will object (i.e., ask the court to "quash" the subpoena) or whether the counselor should simply obtain the client's written consent to testify or turn over her records. An objection can be based on a number of grounds and can be raised by any party, as well as by the person whose treatment information is sought. Often, the counselor may assert the client's privilege for her.

If the program has an attorney to represent it or an attorney who is willing to provide advice on issues like these, the counselor could seek his advice. As is detailed in Appendix B, the best way to handle this arrangement is for the program and the lawyer to sign a "Qualified Service Organization Agreement" (§§2.11, 2.12(c)(4)), which permits the program to

Project Connect Coordinating Committee

In Rhode Island, the Project Connect Coordinating Committee meets monthly to explore and establish linkages between treatment agencies. Its members include representatives of the Department of Children, Youth, and Families (DCYF); the Department of Health, Division of Substance Abuse; substance abuse treatment providers; health care providers; staff from perinatal addiction programs funded by the Center for Substance Abuse Prevention; and staff for Project Connect. Among the project's accomplishments are the following:

- Holding a treatment provider fair to give DCYF a better grasp of treatment issues and options
- Preparing a resource directory to help DCYF workers make appropriate referrals
- Developing referral, intake, and reporting procedures to integrate and facilitate the work of substance abuse treatment providers and DCYF workers serving the same family
- Sponsoring a conference to work toward a common language
- Exchanging information through formal presentations on topics of mutual concern
- Advocating for the development and implementation of a managed care system

Source: Allen, 1996.

communicate information to a person or agency that provides services to the program.

Communicating with the court

Sometimes, the court hearing a client's case will ask a treatment program to write a report about his progress in treatment. Or a client's lawyer may ask an agency to submit a letter to the court to support a disposition she is advocating. In any letter it submits, the agency should limit itself to reporting factual information, such as client attendance and urine toxicology screen results; it should not speculate on the future of the client or the client's family. Nor should it offer an opinion as to where the child should be placed. Of course, any information the agency releases in the form of a letter-report must be limited to the kind and amount of information the client agreed to have released when he signed the consent form. Moreover, the agency should consult with the client's attorney to ensure the letter covers the areas of concern and will do no damage.

What should a counselor do if the client is continuing to abuse the child, the counselor knows this, and the counselor is asked to submit a report? First, if a counselor believes that her client is continuing to abuse a child and that the child's life or health is in danger, the counselor can make another "initial" report to the CPS agency (even when no report has been requested).

Second, if the client's lawyer has asked the counselor to write a report for the court and the counselor believes that the client is continuing to have difficulty meeting his parenting responsibilities (but that active abuse that would require another report is not present), the counselor can explain why she doesn't want to write a report, so long as the client has signed a consent form permitting the counselor to talk to the lawyer.

Third, if the court has asked the program for a report, the counselor can state in the beginning of the report that it will be limited to factual matters related to the client's progress and compliance with substance abuse treatment. The only circumstance in which a counselor could voluntarily inform a court of his opinion that there was ongoing abuse would be when the client's signed consent form would permit this kind of communication.

Finally, if the court insists on a report (or testimony) on the subject of the client's parenting and the client has not consented to such communications, the program must explain that in order for the counselor to report (or testify) on this issue, the court must issue an order under subpart E of the Federal regulations. Note that if the report or testimony will include "confidential communications" it can only be done if the disclosure

- Is necessary to protect against a threat to life or of serious bodily injury
- Is necessary to investigate or prosecute an extremely serious crime (including child abuse)
- Is in connection with a proceeding at which the client has already presented evidence concerning confidential communications (for example, "I told my counselor…") (§2.63) (see Appendix B)

Responding to inquiries by law enforcement

If a client faces criminal child abuse or neglect charges, a police officer, detective, or probation officer may pay the counselor a visit. If any of these officials asks a counselor to disclose information about a client or her treatment records, the counselor should handle the matter in the same way he would handle it with a lawyer. The counselor should tell the officer, as he might a lawyer, "I can't tell you if I have a client with that name. I'll have to check my records." Of course, if the client was mandated into treatment in lieu of prosecution or incarceration and has signed a criminal justice system consent form authorizing communication with the mandating agency, program staff may be obligated to speak with someone from that agency. (See discussion in Appendix B.)

If the officer's inquiry has come unexpectedly, the counselor should determine from the client whether she knows the subject of the officer's inquiry; whether she wants the counselor to disclose information and, if so, how much and what kind; and whether there are any particular areas the client would prefer she *not* discuss with the officer. Again, the counselor must obtain written consent from the client before he speaks with the officer. If the client has a criminal case pending against her, it is best to check with her lawyer, too.

Maintaining Working Relationships With CPS Agencies and Others

While a treatment program and a CPS agency may have conflicts regarding certain clients' cases, the program needs to maintain a good working relationship with the CPS agency and other agencies involved in the child protection system. It is possible, outside the context of any individual case, for treatment programs, CPS agencies, and others to work together to develop common approaches to improve family functioning, reduce substance use, and keep children safe. Many States have coordinating committees to exchange information among diverse agencies about goals and strategies to promote understanding of each agency's perspectives, needs, and legal constraints (see box above).

Education and outreach by substance abuse treatment agencies is particularly important, because CPS agency workers and other individuals in the child protective system often

- View treatment agencies as lenient on substance abusers
- Have difficulty understanding or respecting the treatment process, particularly relapse
- Do not understand or accept the constraints imposed on treatment agencies by Federal confidentiality requirements

Providing a forum for these misunderstandings to be resolved and for acceptance and respect to develop will benefit all concerned.

The following are examples of the ways that treatment providers in some States and communities have engaged in education and outreach:

- Florida drug treatment providers educate State legislators, judges, and sheriffs through conferences and seminars. Events are locally organized and help create understanding and acceptance of the treatment process and the confidentiality requirements that affect the provider.
- In Vermont, the State funds seminars on family violence and substance abuse treatment options for judges and other members of the legal system. These seminars are also open to the public.
- Some communities hold regular brown bag lunches for probation officers and others in the legal system. These meetings are an opportunity for education on such issues as confidentiality or how to work through problems, such as discrepancies between what the court is mandating (e.g., enrollment in a residential treatment program) and what is available (e.g., only nonresidential programs).
- Every summer Texas holds an annual Institute on Alcohol and Drug Abuse 2-week event that usually has 1,500 attendees per week. Numerous private and nonprofit providers have booths to exhibit their services. Bookstores exhibit and sell literature on such subjects as substance abuse, health, mental health issues, marriages, relationships, cultures, and motivational stories. A "Best Practices Conference" is held in the winter with about 1,200 people in attendance. Trainings are provided throughout the year in various regions of the State to make attendance convenient and more cost-effective for the providers.
- The Community Youth Network in Grayslake, Illinois, provides training sessions to area law enforcement personnel and school personnel. They address both victim and perpetrator issues, which is unusual because many programs do not address perpetrator treatment.
- Community Advisory Boards are an effective method of interagency collaboration and networking. The integrated family treatment program in San Antonio, Texas, has an active Community Advisory Board with representatives from the CPS system, Criminal Justice System, District Attorney's office, Family Violence Unit, Health Department, battered women's shelters, and other support agencies. Monthly meetings are held to exchange ideas and programmatic information, develop advocacy for substance-using women within their respective agencies, and gain an understanding of how each local system works.
- In Connecticut, the Alcohol and Drug Policy Council created a Women and Children's Client-Based Model. The various State agencies have been meeting to discuss implementing the model. There are monthly meetings of Child Protective Services Substance Abuse Regional Resource Consultants (psychiatric social workers with substance abuse certification who are internal consultants to the CPS agency) with the substance abuse case managers for women and children to go over cases and resources. Both systems fund services for the population. The CPS system funds Project SAFE (Substance Abuse Family Evaluation), which is a statewide system to screen and provide priority access for evaluation and outpatient substance abuse treatment for clients in the CPS system. Another project, Supportive Housing for Recovering Families, provides housing assistance for clients who have successfully completed residential treatment and are planning to reunify with

their families. The Alcohol and Drug Policy Council also recommends cross-training between substance abuse treatment programs and CPS agencies. Some of the major issues are how to make treatment systems more family focused and how to break down the traditional barriers in funding and measures.

- In Louisiana, recovered survivors have become effective lobbyists within the State legislature. Their personal experiences are brought into legislative subcommittees to gain more stringent, effective laws on behalf of abused children. The Louisiana State legislature has an appointed official in the victim representative capacity whose primary qualification is being a recovered survivor of childhood victimization.
- Montgomery County, Maryland, has a task force to integrate adult treatment services within the social services of CPS agencies, welfare and housing, and the juvenile justice system, recognizing the shared interests and client base.
- The Child Welfare League of America has published a book called *Responding to Alcohol and Other Drug Problems in Child Welfare* that includes many references and resources (Young et al., 1998).

More needs to be done, however. Many State legislatures still view substance abusers as criminals, not people who have a disease. With busy schedules and limited financial resources, law enforcement officials often prefer incarcerating individuals, where treatment is limited. (For more information on substance abuse treatment and criminal offenders, refer to TIP 30, *Continuity of Offender Treatment for Substance Use Disorders From Institution to Community* [CSAT, 1998b].)

Education is a two-way street. Treatment programs may benefit from training provided by other agencies, including CPS agencies and law enforcement organizations. Civic organizations, such as the Rotary Club, often have a speaker's bureau that may recommend a local expert in a particular field who would speak pro bono.

7 Emerging and Continuing Issues

Alcohol and drug counselors treating clients who are involved with the child protective services (CPS) system should be aware of a number of emerging trends. These include limits on the length of time clients can remain on public assistance and increased demands on clients receiving aid, reforms enacted to the child welfare system that require CPS agencies to place far greater emphasis on children's health and safety and on permanent placement of children versus maintenance of parental rights, and constraints imposed upon substance abuse treatment by managed care.

Continuing trends also challenge providers to adapt new treatment regimes, acquire new skills, and advocate for client needs. While drug courts continue to provide mandated treatment for some substance abusers, a countertrend toward punishing substance abusers—especially pregnant mothers who have been prosecuted under abuse or neglect statutes—is evident in many State legal systems. The ever-changing demographics of drug use present new challenges, as an aging cohort of substance abusers are now parents to older children who are themselves at risk for substance abuse disorders. Increasingly detected through improved screening, clients with multiple diagnoses present complex needs that can be met only through collaboration and lobbying of managed care officials about the need for more complex treatment. At the same time, counselors continue to face requirements for professional education that require considerable expenditures of both time and money.

The Impact of New Legislation on Parents in Treatment

In 1996, Congress enacted a major overhaul of welfare called The Personal Responsibility and Work Opportunity Reconciliation Act. It transformed the Aid to Families with Dependent Children (AFDC) program, which entitled qualified individuals with dependent children to assistance, into Temporary Assistance for Needy Families (TANF), a program offering limited relief. Unlike AFDC, TANF imposes work requirements on aid recipients, limits the amount of time adults can receive benefits, and bars benefits to certain categories of persons, such as individuals with felony drug convictions. TANF will undoubtedly have a major impact on parents in treatment. Refer to the forthcoming TIP, *Integrating Substance Abuse Treatment and Vocational Services* (CSAT, in press [a]), for an expanded discussion of welfare reform and substance abuse treatment.

In addition to TANF, Congress has established a series of programs and funding streams that are designed to

- Extend services to troubled families to help them to remain intact or to reunite (i.e., family support and preservation services)
- Provide Federal payments to support foster care when children must be placed outside the home
- Expedite permanent placement for children who cannot be reunited with their families
- Provide assistance to increase the number of adoptions of children in foster care

To qualify for funding, State child welfare programs must implement specific timetables and goals designed to expedite the return of children placed in foster care to their families or free them for adoption.

The requirements and limitations Federal law places on States receiving Federal funding for child welfare and child protective services may have a profound impact on parents in treatment. Depending on how each State implements the law, the following examples illustrate how parents in treatment may be affected:

- *States may be less tolerant of children living with substance-abusing parents.* As States implement the requirement that the child's health and safety be the paramount concern, they may take a less tolerant view when children are living in households with one or more adults who abuse substances.
- *Parents will have less time to comply with CPS agency mandates.* As the 15-month time limit on maintaining the child in foster care goes into effect and States enforce requirements regarding prompt determinations about children's permanent placement, parents who cannot achieve sobriety after a year of treatment or otherwise comply with CPS agency mandates may be at greater risk of losing their parental rights. They may also lose the funding supporting their treatment.
- *Parents with previous CPS agency involvement may lose parental rights quickly.* Clients in treatment who have previously lost parental rights to another child may receive an expedited proceeding that denies them family preservation services and their rights to children currently in their care.

Family Preservation and "Fast-Track" Adoption

The Federal government has established a series of programs to fund and support States' efforts to help children and their families in crisis. These programs include Family Support and Family Preservation Services to strengthen family stability and facilitate the safe reunification of a child who has been removed from the home and Foster Care and Adoption Promotion and Support Services that support both the maintenance of foster care and encourage more adoptions out of the foster care system.

These programs provide funding to States, but they also require States to adopt a number of important policies, timetables, and restrictions, including a significant emphasis on children's health and safety, permanent placement, prompt development, and frequent review of service plans; time limits on family reunification services; and speedier termination of parental rights. In effect, the 1997 amendments to the Family Preservation and Support Services Act changed the emphasis from family preservation to child health and safety. This means that ensuring the child's developmental stability now takes precedence over extending "reasonable efforts" to reunify the family. For a more detailed explanation of this law and recent welfare reform laws, see Appendix C.

Consequences of Losing Public Assistance

Parents whose public assistance is reduced or terminated (e.g., because of changes in welfare law) may have difficulty providing their children with basic levels of food, clothing, shelter, and medical care. Will they find themselves charged with child neglect or abuse as a result? Most States prohibit a finding of child abuse or neglect if parents fail to provide the necessities of life because of poverty; however, it is not clear what will happen if their inability to provide is due to their failure to comply, for example, with welfare-to-work requirements. Treatment clients who lose public assistance may also lose their eligibility for Medicaid, which in some States pays for treatment.

The child welfare system provides Medicaid benefits for all children in its care. Some States also provide Medicaid benefits for children living at home but in open CPS cases. In many States, however, parents are not eligible for Medicaid. Advocacy for entitling Medicaid benefits to those parents who are involved in the CPS system would benefit such parents who are seeking, or seeking to complete, treatment.

The Combined Impact of Welfare Reform and Changes in Child Welfare Laws

The combined effect of new welfare reform requirements and changes in child welfare laws may place great pressure on parents involved with CPS agencies. To avoid losing their children, parents may be required to enter treatment, achieve sobriety, or meet other expectations from the CPS agency, all within a limited time period. Similarly, under TANF, welfare authorities may impose work requirements and sanction those who fail to comply.

Those with substance abuse disorders, minimal work experience, and a lack of parenting skills can feel overwhelmed by these growing demands. Staying sober, by itself, is a difficult achievement for many. If they have to comply with work requirements and assume new parenting responsibilities, they may see all of this as impossible. For some, the response will be denial of the reality that the system has changed. Others may be overcome by hopelessness and be inclined to give up. Other parents will relapse. With the States placing greater emphasis on children's health and safety and permanent placement, any one of these responses could mean loss of parental rights. Moreover, States that choose to test welfare recipients for drug abuse may quickly detect a relapse, which could result in the reduction or elimination of benefits. Or a child welfare agency might conclude that a relapse means that reasonable efforts to preserve or reunite the family are no longer consistent with the goal of a safe and stable environment for the child.

As welfare reform and changes in child protection laws are implemented, counselors will see increasingly stressed parents in need of supportive counseling and a web of other services. In these changed times, however, support will not suffice. If the parent in treatment is to emerge with her family intact, the counselor must combine support with a firmness rooted in the understanding that the rules in this area have changed and become less forgiving. The continuing challenge for counselors in the years ahead will be to provide support to clients while conveying to them the urgency of attaining or maintaining sobriety.

Emerging Issues

Managed Care

More persons entering treatment are paying for their services through managed care systems that place limitations on the type and amount of treatment provided. Medicaid, Medicare, and welfare benefits, once provided through private insurance, are all being allocated to managed care. Accountants and other nonhealth professionals who may have limited health care background often are making treatment decisions. Typically, clients are receiving authorizations for fewer sessions at less intensity. A client who required safe detoxification once was funded for 21 days; now, limited funding allows for only 2 days. In the late 1970s, a pregnant substance-dependent mother could stay in the hospital for 5 days. Now, she is discharged almost immediately after giving birth.

The amount of time most agencies must spend on the telephone with managed care representatives is staggering. Services a doctor or counselor believes are medically necessary are frequently denied (Rabasca, 1998). Programs once referred clients freely to appropriate services; now, additional services with lengthy justifications must be preapproved. Rather than taking into account the individual's circumstances, insurance representatives use reference manuals, such as the American Society of Addiction Medicine's (ASAM) *Patient Placement Criteria for the Treatment of Substance-Related Disorders*, 2nd edition (ASAM, 1996) or the *Green Spring Health Services Medical Necessity Criteria for Utilization Management* (Nyman et al., 1992), to determine the appropriate level of care.

Clients with childhood abuse and neglect issues as well as a substance abuse disorder may face managed care restrictions on the number of visits they can make to mental health services. Managed care often will not pay for sexual abuse or physical abuse assessments and evaluations if the State is involved, often looking to the State to provide them; this complicates access to services. These restrictions may mean that both problems cannot be adequately addressed, particularly given the fact that abuse issues often do not surface until late in treatment, when the allotted number of visits may be nearly exhausted. Often by the time additional visits are approved, the continuity of therapy needed for the best chance of success may have been lost. Managed care may also deny treatment to clients with childhood abuse and neglect issues because they are not sufficiently motivated to deal with these problems.

In several surveys of members of the American Psychological Association (APA), respondents reported that managed care created ethical dilemmas in which they were required to report confidential patient information as a condition of reimbursement (Clay, 1998). Clearly, such dilemmas are of particular concern in cases of substance abuse disorder because they may also involve issues of child abuse and neglect. (See TIP 24, *A Guide to Substance Abuse Services for Primary Care Clinicians* [CSAT, 1997a], for more information on the legal and ethical issues involved in sharing information with insurers and other third-party payors.)

The strong backlash against such policies has recently resulted in legal actions at both State and Federal levels. Legislation is also under consideration at the State and Federal levels to increase accountability for the health outcomes of managed care agencies. In 1996, five States passed laws protecting consumers from managed care abuses; in 1997, 17 more States took such actions (Clay, 1998).

Implications for providers include the following:

- *Know how to "work the system" and speak the language of managed care.* Some counseling agencies hire an individual specifically to perform this task. It is especially important to know a company's stated placement criteria. In cases of current child abuse, counselors should be aware that when a CPS agency is involved, the capitation rate might be higher because it is expected that more services will be used. Because the managed care company is allocating more money per client, there should be a greater capacity to support substance abuse treatment that will benefit the entire family.
- *Consider innovative strategies.* In Florida, for example, five major substance abuse

treatment programs combined and created their own managed care company so that they could compete with other managed care companies.

- *Develop the capacity for different modalities of treatment.* For example, a managed care caseworker refuses to authorize residential treatment for a person who has a history of substance dependency, is currently using, and has no motivation for treatment. The counselor as provider may set up smaller goals to work within the system, proceeding with low intensity motivational counseling once or twice a week. At the end of the authorized treatment period, the counselor may be able to report increased motivation and succeed in having a higher level of care authorized.
- *Have proof that the treatment program or agency is successful and ultimately saves money.* A treatment program can demonstrate its contributions by maintaining data on quality assurance and program evaluations that the program manager can use when he works with the managed care administrator. Counselors should also be prepared to provide factual data to demonstrate problems that have arisen from system constraints.

Although counselors and treatment program administrators often focus on the negative impact of managed care, this trend can benefit clients by providing incentives for developing interagency collaborations and satellite clinics in different settings. In the not too distant past, few counseling programs would have been enthusiastic about locating a treatment program within a primary care clinic or a satellite child guidance clinic within a methadone maintenance treatment program. Today, although these ideas are still novel, they are by no means unthinkable. Since no one agency is likely to be able to meet all the needs of a family affected by substance abuse, particularly one in which child abuse or neglect has occurred, closer collaboration among services may result in more effective, family-oriented approaches to intervention.

As legislators address managed care issues, counselors can be effective advocates, working to ensure that the care their clients need is available. By working proactively with others to raise systemic issues, counselors can ensure their concerns are represented in the legislative process. Vocal, clear, factual communication can help hold State and managed care agencies accountable for the results of their policies. (For more information on managed care, see TIP 27, *Comprehensive Case Management for Substance Abuse Treatment* [CSAT, 1998a].)

Increased Accountability

Increasingly, funders are holding CPS agencies, health care services, and substance abuse treatment programs accountable for demonstrating specific outcomes. Programs must be prepared to demonstrate their effectiveness using objectively verifiable outcome measures. Failure to meet established goals may result in a loss of funding or in mandated systemic changes. The individual counselor may be asked to provide both qualitative and quantitative data (such as case histories) to demonstrate the quality of care she is giving. Such evaluations can be expensive.

Clients who are in treatment counseling and also receiving services from other agencies (which is often true of those involved in allegations of child abuse and neglect) may be assessed repeatedly through interviews and questionnaires. The counselor can help prepare clients for this invasive mandated reporting by emphasizing its potential benefits. Although time consuming to collect, such data provide a valuable opportunity to streamline programs and improve services.

Class action suits have been filed in Federal courts against child welfare agencies in several

States, resulting in many of them being placed under some form of Federal supervision. The mechanisms in place to hold the agencies accountable could affect substance abuse counselors in these States, who may receive increased requests for case and outcome data from agencies that must report to the court. A counseling agency that has a contract with a CPS agency should be prepared to demonstrate that the services provided are likely to affect the outcome positively or risk losing funding.

Concerning accountability, some jurisdictions are moving to open family court hearings. (The Adoption and Safe Families Act now requires that foster parents be notified of all hearings and be given the opportunity to testify.) Clients will be affected because their cases, along with their substance abuse, are being made public. CPS agencies will be held more accountable because their work will be open to public scrutiny.

Interagency Collaboration

From the Federal to the community level, changes are being made that influence the way substance abuse treatment agencies deliver services. Increasingly, agencies must communicate and collaborate to meet a client's needs under the constraints posed by funding limitations, applicable laws, and managed care policies. Some counseling agencies have merged with other service agencies in order to deal with administrative burdens such as reporting requirements and the need to work intensively with managed care representatives. Many Federal grants require public–private partnerships and multidisciplinary treatment strategies formalized through memoranda of understanding.

As agencies become more accustomed to working together, their attitudes toward collaboration also are changing. Agencies increasingly cross borders that were once sacrosanct. Practitioners are more aware that research and experience have demonstrated the importance of a wide range of support services (such as transportation, housing, and day care) for increasing the effectiveness of counseling (Feig, 1998). As a consequence, the role of the treatment provider is changing from one who works in relative isolation to one who is a partner within an integrated system.

Many traditional treatment agencies are expanding their practice to incorporate mental health services. By doing so, they make treatment more accessible for clients with coexisting disorders. For example, an adult survivor who has mental health issues and is also a substance abuser may receive treatment for both needs at the same location. Such close partnerships provide a more cohesive approach to meeting clients' needs. In addition, this approach may provide a more solid funding base for agency services. The U.S. Department of Health and Human Services (DHHS) is committed to leading efforts to improve collaborative working relationships between the child welfare and substance abuse treatment fields and to supporting States' efforts to do the same. The Department's recent report to Congress, *Blending Perspectives and Building Common Ground*, describes several programs that can assist States and local communities in expanding substance abuse treatment for clients in the child welfare system, including the Substance Abuse Prevention and Treatment Block Grants, the Targeted Capacity Expansion Program, and Medicaid (DHHS, 1999).

An innovative program in Connecticut by the Department of Children and Families (DCF) called Project SAFE (Substance Abuse Family Evaluation) directly links CPS agencies with substance abuse treatment (see Chapter 5). The experience over the past 3 years has led to more than 20,000 unduplicated referrals from CPS agencies to a statewide network of substance abuse treatment providers. Project SAFE provides priority access to substance abuse evaluations, drug testing, and various outpatient substance abuse services to clients identified by the CPS agency. Referrals are coordinated from the beginning through a statewide network that also coordinates other payment responsibilities. The Project has led to communication and a definition of roles and response guidelines between CPS agencies and the substance abuse treatment system.

Connecticut's DCF recently created Supportive Housing for Recovering Families, which will provide drug-free housing assistance and case management for families who are reunifying and making a transition to the community after successful residential substance abuse treatment. DCF is working on outreach approaches once the CPS agency and Project SAFE identify a client as needing substance abuse treatment. DCF is also collaborating with the academic community to pilot motivational enhancement training and approaches to both the CPS and substance abuse treatment system as well as case management services.

In the current environment, traditional funding sources are drying up, and many traditional programs are going out of business. Moreover, many Federal grants and contracts are now aimed at collaborative efforts. Once there were many funding streams; now there are only a few State-subsidized funding sources. Persistent, creative fundraising is essential, and success almost always depends on proactive strategies to form collaborations. Agencies must clearly define their responsibilities and nurse the relationships they will need to seek funding in innovative partnerships. Program funding may come from drug courts or from CPS agencies, which now have the flexibility to use a portion of their funding to support substance abuse treatment (see Figure 7-1).

Continuing Trends

Changing Demographics Of Drug Use

Over the past 20 years, the number of people over 35 years of age using illicit substances has increased significantly (Substance Abuse and Mental Health Services Administration [SAMHSA], 1996). The 1995 *National Household Survey on Drug Abuse* indicates there is a large cohort of aging substance-abusing parents:

> In general, the aging of people in the heavy drug-using cohorts of the late 1970s, many of whom continue to use illicit drugs, has diminished any observable reductions in use among the 35+ age group and has resulted in an overall shift in the age composition of drug users.... For example, in 1985, 19 percent of

Figure 7-1

Linking Child Welfare and Substance Abuse Treatment Systems

In a unique program currently being developed, the Connecticut Department of Children and Families plans to make voluntary substance abuse disorder assessments available to parents involved in CPS agency investigations, thus establishing a direct link between the child welfare and substance abuse treatment systems. Through use of a telephone referral system maintained by a managed care company with a network of 43 providers, child welfare workers with questions about the severity of parental substance use can secure appointments for evaluation on a priority basis. The program will provide rapid reporting of results and priority access to treatment when necessary. By directly linking the two systems, the agency hopes to decrease the risk of continued abuse or neglect, enhance decisionmaking about service needs, facilitate admission to substance abuse treatment, and reduce the need for out-of-home placement.

cocaine-related episodes involved persons age 35 or older. By 1995, this percentage had increased to 42 percent (SAMHSA, 1996).

Epidemiological surveys indicate that actual substance dependence occurs most frequently during early to middle adulthood, when a substantial proportion of the general population is parenting minor children (Anthony et al., 1994). Consequently, treatment providers should continue to expect to find many parents of minor children in their caseload, with the attendant possibility of substance-related child abuse or neglect.

Gender Issues

Some research now suggests that gender differences are an important factor in addiction and recovery (Magura and Laudet, 1996). When counseling clients whose families are affected not only by substance abuse but also by child abuse and neglect, research suggests that counselors can best meet the clients' needs by taking these gender-specific factors into account (Coletti et al., 1997).

Women who are pregnant or parenting need "family-oriented services providing comprehensive care as well as parenting and family skills training, all of which usually remain unaddressed in traditional drug treatment" (Magura and Laudet, 1996, p. 203). In the opinion of many researchers, the absence of such specialized interventions may well result in an increased incidence of child abuse and neglect, as well as increased out-of-home placement (Magura and Laudet, 1996). Programs that meet such needs can help engage pregnant and parenting women and improve treatment for them, but such services are still not widely available (see Chapter 6).

Men's roles as fathers also should not be ignored in providing substance abuse treatment. It is true that among clients who are parents, women are more likely to have children in their care and men more likely to be estranged from their children. But surveys of representative samples indicate that in the general population far more fathers than mothers have substance abuse disorders (DHHS, 1994) and men consistently outnumber women in all types of treatment (Gerstein et al., 1997). Consequently, though it is true that a greater *proportion* of women entering treatment are mothers and are more likely to have minor children in their care, the *numbers* of men and women seeking help who are parents are about the same (DHHS, 1999).

Changes in welfare laws now require a mother receiving welfare to identify the father of her children. Consequently, fathers who seemed nearly irrelevant in the recent past have regained visibility. Legal changes in welfare laws also allow fathers to be present in the home without the loss of financial support. Historically, in an abuse or neglect situation, CPS agencies have worked to keep the mother and children together but assumed that an abusing father should leave the family; this view, however, appears to be changing. Fathers are increasingly recognized and supported, with resulting benefits for children. Courts are discovering the value of paternal relatives as placement options for children. As substance abuse among women rises and women continue to be disproportionately affected by the AIDS epidemic, fathers in treatment may become viable placement options for children whose mothers cannot care for them.

Fathers are increasingly motivated to assume a greater share of parenting responsibilities. Over the past 20 years, a number of social forces have converged to create new definitions of fatherhood. If these trends continue, more men who enter treatment may see parenting as part of their identity as men, and more of them may be distressed about their inability to function effectively as fathers because of substance abuse. Paternal substance abuse (most commonly paternal alcoholism) has been associated with spousal abuse, parental neglect, and failure to provide financial support (Chassin et al., 1996; Dion et al., 1997; Dukma and Roosa, 1995; Egami et al., 1996; Ichiyama et al., 1996). Because many fathers today show an increased willingness to work toward change for the benefit of their children, the treatment provider would be well advised to use this information to help motivate male clients.

More practitioners in other settings are now actively concerned with the client as father and are conducting research to define associated issues and needs.

On a limited basis, some substance abuse researchers are engaged in developing interventions to build parenting skills that are offered to both men and women (Luthar and Walsh, 1995). Prisons sometimes offer courses in parenting to male inmates. Specialized interventions have also been designed for teenage fathers, fathers with newborn infants, newly divorced fathers, and fathers with families on welfare. However, gender-specific interventions targeting the specific needs and concerns of fathers with substance abuse disorders still need to be developed and tested.

Appendix A
Bibliography

Allen, D.; Lovejoy-Johnson, A.; Holloway, E.; Robbins, J.; and Woods, S. Fostering collaboration: Substance abuse providers working together. *Common Ground* January 1996. pp. 7, 11.

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV), 4th ed. Washington, DC: American Psychiatric Association, 1994.

American Society of Addiction Medicine. *Patient Placement Criteria for the Treatment of Substance-Related Disorders*, 2nd ed. Chevy Chase, MD: American Society of Addiction Medicine, 1996.

Anthony, J.C.; Warner, L.A.; and Kessler, R.C. Comparative epidemiology of dependence on tobacco, alcohol, controlled substances, and inhalants: Basic findings from the National Comorbidity Survey. *Experimental and Clinical Psychopharmacology* 2:244–268, 1994.

Armstrong, J. Psychological assessment. In: Spira, J.L., and Yalom, I.D., eds. *Treating Dissociative Identity Disorder*. San Francisco: Jossey-Bass, 1996. pp. 3–38.

Arroyo, J.A.; Simpson, T.L.; and Aragon, A.S. Childhood sexual abuse among Hispanic and non-Hispanic White college women. *Hispanic Journal of Behavioral Sciences* 19(1):57–68, 1997.

Barker, L.R., and Whitfield, C.L. Alcoholism. In: Barker, L.R.; Burton, J.R.; and Zeive, P.D., eds. *Principles of Ambulatory Medicine*. Baltimore: Williams & Wilkins, 1991.

Barnett, D.; Manly, J.T.; and Cicchetti, D. Continuing toward an operational definition of psychological maltreatment. *Development and Psychopathology* 3:19–29, 1991.

Baumrind, D. Current patterns of parental authority. *Developmental Psychology Monographs* 4:1, Pt. 2, 1971.

Beck, A.T. *Depression: Clinical, Experimental, and Theoretical Aspects*. New York: Harper & Row, 1967.

Beck, A.T., and Beck, R.W. Screening depressed patients in family practice: A rapid technic. *Postgraduate Medicine* 52(6):81–85, 1972.

Beckman, L.J., and Ackerman, K.T. Women, alcohol, and sexuality. In: Galanter, M., ed. *Recent Developments in Alcoholism*. Vol. 12, *Women and Alcoholism*. New York: Plenum Press, 1995. pp. 267–285.

Beitchman, J.H.; Zucker, K.J.; Hood, J.E.; daCosta, G.A.; Akman, D.; and Cassavia, E. A review of the long-term effects of child sexual abuse. *Child Abuse and Neglect* 16:101–118, 1992.

Belsky, J. The determinants of parenting: A process model. *Child Development* 55:83–96, 1984.

Belsky, J. Etiology of child maltreatment: A developmental–ecological analysis. *Psychological Bulletin* 114(3):413–434, 1993.

Bennett, E.M., and Kemper, K.J. Is abuse during childhood a risk factor for developing substance abuse problems as an adult? *Journal of Developmental and Behavioral Pediatrics* 15:426–429, 1994.

Benward, J., and Densen-Gerber, J. Incest as a causative factor in anti-social behavior: An exploratory study. *Contemporary Drug Problems* 4:323–340, 1975.

Berkowitz, M. Therapist survival: Maximizing generativity and minimizing burnout. *Psychotherapy in Private Practice* 5:85–89, 1987.

Bernstein, D.P.; Fink, L.; Handelsman, L.; Foote, J.; Lovejoy, M.; Wenzel, K.; Sapareto, E.; and Ruggiero, J. Initial reliability and validity of a new retrospective measure of child abuse and neglect. *American Journal of Psychiatry* 151(8):1132–1136, 1994.

Bernstein, E.M., and Putnam, F.W. Development, reliability, and validity of a dissociation scale. *Journal of Nervous and Mental Disease* 174(12):727–735, 1986.

Besharov, D.J. *Recognizing Child Abuse: A Guide for the Concerned.* New York: The Free Press, 1990.

Besharov, D.J., and Laumann, L.A. Don't call it child abuse if it's really poverty. *Journal of Children and Poverty* 3(1):5–36, 1997.

Bisbey, L.B. "No Longer a Victim: A Treatment Outcome Study of Crime Victims With Post-Traumatic Stress Disorder." Ph.D. dissertation, California School of Professional Psychology, San Diego, 1995. University Micro Films International Pub. No.: 952269, 1994.

Blake, D.D. Rationale and development of the clinician-administered PTSD scales. *PTSD Research Quarterly* 5:1–2, 1994.

Blake, D.D.; Weathers, F.W.; Nagy, L.M.; Kaloupek, D.G.; Gusman, F.D.; Charney, D.S.; and Keane, T.M. The development of a clinician-administered PTSD scale. *Journal of Traumatic Stress* 8(17):75–90, 1995.

Boundy, D. Profile: Project SAFE. Reaching out with hope to women. http://www.pbs.org wnet/closetohome/treatment/html/safe. html [Accessed Nov. 16, 1998].

Bowman, E.S. Delayed memories of child abuse: Part II: An overview of research findings relevant to understanding their reliability and suggestibility. *Dissociation: Progress in the Dissociative Disorders* 9:232–243, 1996.

Boyd, C.; Henderson, D.; Ross-Durow, P.; and Aspen, J. Sexual trauma and depression in African-American women who smoke crack cocaine. *Substance Abuse* 18:133–141, 1997.

Brabant, S.; Forsyth, C.J.; and LeBlanc, J.B. Childhood sexual trauma and substance misuse: A pilot study. *Substance Use and Misuse* 32(10):1417–1431, 1997.

Brady, K.T.; Killeen, T.; Saladin, M.E.; Dansky, B.; and Becker, S. Comorbid substance abuse and posttraumatic stress disorder. *American Journal on Addictions* 3:160–164, 1994.

Braun, B. The BASK model of dissociation. *Dissociation* 1:4–23, 1988.

Braver, M.; Bumberry, J.; Green, K.; and Rawson, R. Childhood abuse and current psychological functioning in a university counseling center population. *Journal of Consulting and Clinical Psychology* 39:252–257, 1992.

Bremner, J.D.; Randall, P.; Scott, T.M.; Bronen, R.A.; Seibyl, J.P.; Southwick, S.M.; Delaney, R.C.; McCarthy, G.; Charney, D.S.; and Innis, R.B. MRI-based measurement of hippocampal volume in patients with combat-related posttraumatic stress disorder. *American Journal of Psychiatry* 152(7):973–981, 1995.

Briere, J. Controlling for family variables in abuse effects research: A critique of the "partialling" approach. *Journal of Interpersonal Violence* 3:80–89, 1988.

Briere, J. *Therapy for Adults Molested as Children: Beyond Survival.* New York: Springer Publishing, 1989.

Briere, J. *Child Abuse Trauma: Theory and Treatment of the Lasting Effects.* Newbury Park, CA: Sage Publications, 1992a.

Briere, J. Methodological issues in the study of sexual abuse effects. *Journal of Consulting and Clinical Psychology* 60(2):196–203, 1992b.

Briere, J. *Trauma Symptom Inventory (TSI): Professional Manual.* Odessa, FL: Psychological Assessment Resources, 1995.

Briere, J. Psychometric review of trauma symptom inventory (TSI). In: Stamm, B.H., ed. *Measurement of Stress, Trauma, and Adaptation.* Lutherville, MD: Sidran Press, 1996. pp. 381–383.

Briere, J. Psychological assessment of child abuse effects in adults. In: Wilson, J.P., and Keane, T.M., eds. *Assessing Psychological Trauma and PTSD.* New York: Guilford Press, 1997.

Briere, J., and Conte, J. Self-reported amnesia for abuse in adults molested as children. *Journal of Traumatic Stress* 6:21–31, 1993.

Briere, J.N., and Elliott, D.M. Sexual abuse, family environment, and psychological symptoms: On the validity of statistical control. *Journal of Consulting and Clinical Psychology* 61:284–288, 1993.

Briere, J.N., and Elliott, D.M. Immediate and long-term impacts of child sexual abuse. *Future of Children* 4(2):54–69, 1994.

Briere, J.; Evans, D.; Runtz, M.; and Wall, T. Symptomatology in men who were molested as children: A comparison study. *American Journal of Orthopsychiatry* 58:457–461, 1988.

Briere, J., and Runtz, M. The trauma symptom checklist (TSC-33): Early data on a new scale. *Journal of Interpersonal Violence* 4:151–163, 1989.

Briere, J., and Runtz, M. Augmenting Hopkins SCL scales to measure dissociative symptoms: Data from two nonclinical samples. *Journal of Personality Assessment* 55:376–379, 1990a.

Briere, J., and Runtz, M. Differential adult symptomatology associated with three types of child abuse histories. *Child Abuse and Neglect* 14(3):357–364, 1990b.

Briere, J., and Woo, R. "Child abuse sequelae in adult psychiatric emergency room patients." Paper presented at the annual meeting of the American Psychological Association, San Francisco, CA, 1991.

Briere, J., and Zaidi, L.Y. Sexual abuse histories and sequelae in female psychiatric emergency room patients. *American Journal of Psychiatry* 146(12):1602–1606, 1989.

Brown, B.S. Drug use—chronic and relapsing or a treatable condition? *Substance Use and Misuse* 33:2515–2520, 1998.

Brown, D.; Scheflin, A.; and Whitfield, C.L. Recovered memories: The current weight of the evidence in science and in the courts *Journal of Psychiatry and Law* 27(1):5–156, 1999.

Brown, H.M. Shame and relapse issues with the chemically dependent client. *Alcoholism Treatment Quarterly* 8(3):77–82, 1991.

Brown, P.J.; Recupero, P.R.; and Stout, R. PTSD substance abuse comorbidity and treatment utilization. *Addictive Behaviors* 20(2):251–254, 1995.

Brown, P.J.; Rubin, A.; Longabaugh, R.; Stout, R.; and Wolfe, J. "Trauma history as a relapse risk factor." Paper presented at the annual meeting of the International Society for Traumatic Stress Studies, San Antonio, TX, 1993.

Browne, A., and Finkelhor, D. The impact of child sexual abuse: A review of the literature. *Psychological Bulletin* 99(1):66–77, 1986.

Bryer, J.B.; Nelson, B.A.; Miller, J.B.; and Krol, P.A. Childhood sexual and physical abuse as factors in adult psychiatric illness. *American Journal of Psychiatry* 144:1426–1430, 1987.

Buriel, R.; Loya, P.; Gonda, T; and Klessen, K. Child abuse and neglect referral patterns of Anglo and Mexican Americans. *Hispanic Journal of Behavioral Sciences* 1:215–227, 1979.

Burnam, M.A.; Stein, J.A.; Golding, J.M.; Siegel, J.M.; Sorenson, S.B.; Forsythe, A.B.; and Telles, C.A. Sexual assault and mental disorders in a community population. *Journal of Consulting and Clinical Psychology* 56:843–850, 1988.

Burnett, B.B. The psychological abuse of latency age children: A survey. *Child Abuse and Neglect* 17:441–454, 1993.

Cahill, C.; Llewelyn, S.P.; and Pearson, C. Long-term effects of sexual abuse which occurred in childhood: A review. *British Journal of Clinical Psychology* 30:117–130, 1991.

Carlson, E.B. *Trauma Assessments: A Clinician's Guide.* New York: Guilford Press, 1997.

Carlson, E.B.; Putnam, F.W.; Ross, C.A.; Torem, M.; Coons, P.; Dill, D.L.; Loewenstein, R.J.; and Braun, B.G. Validity of the Dissociative Experiences Scale in screening for multiple personality disorders: A multicenter study. *American Journal of Psychiatry* 150(7):1030–1036, 1993.

Carran, D.T.; Nemerofsky, A.; and Kerins, M. Risk of unsuccessful program completion for students with serious emotional/behavioral disorders: An epidemiological risk analysis. *Behavioral Disorders* 21:172–189, 1996.

Carroll, K.M. Relapse prevention as a psychosocial treatment: A review of controlled clinical trials. In: Marlatt, G.A., and VandenBos, G.R., eds. *Addictive Behaviors: Readings on Etiology, Prevention, and Treatment.* Washington, DC: American Psychological Association, 1997. pp. 697–717.

Carter, J.H. Racism's impact on mental health. *Journal of the National Medical Association* 86:543–547, 1994.

Catalano, R.F.; Haggerty, K.P.; and Gainey, R.R. *Prevention Approaches in Methadone Treatment Settings: Children of Drug Abuse Treatment Clients* (SDRG Pub. No. 127). Seattle, WA: Social Development Research Group, University of Washington, 1993.

Catherall, D.R., and Shelton, R.B. Men's groups for posttraumatic stress disorder and the role of shame. In: Andronico, M.P., ed. *Men in Groups: Insight, Interventions, and Psychoeducational Work*. Washington, DC: American Psychological Association, 1996. pp. 323–337.

Cavalcade Productions. *Vicarious Traumatization: (I) The Cost of Empathy; (II) Transforming the Pain*. Two-tape set of training videos. Nevada City, CA: Cavalcade Productions, 1997.

Center for Substance Abuse Treatment. *Screening and Assessment for Alcohol and Other Drug Abuse Among Adults in the Criminal Justice System*. Treatment Improvement Protocol (TIP) Series, Number 7. DHHS Pub. No. (SMA) 94-2076. Washington, DC: U.S. Government Printing Office, 1994.

Center for Substance Abuse Treatment. *Developing State Outcomes Monitoring Systems for Alcohol and Other Drug Abuse Treatment*. Treatment Improvement Protocol (TIP) Series, Number 14. DHHS Pub. No. (SMA) 95-3031. Washington, DC: U.S. Government Printing Office, 1995.

Center for Substance Abuse Treatment. *Treatment Drug Courts: Integrating Substance Abuse Treatment With Legal Case Processing*. Treatment Improvement Protocol (TIP) Series, Number 23. DHHS Pub. No. (SMA) 96-3113. Washington, DC: U.S. Government Printing Office, 1996.

Center for Substance Abuse Treatment. *A Guide to Substance Abuse Services for Primary Care Physicians*. Treatment Improvement Protocol (TIP) Series, Number 24. DHHS Pub. No. (SMA) 97-3139. Washington, DC: U.S. Government Printing Office, 1997a.

Center for Substance Abuse Treatment. *Substance Abuse Treatment and Domestic Violence*. Treatment Improvement Protocol (TIP) Series, Number 25. DHHS Pub. No. (SMA) 97-3163. Washington, DC: U.S. Government Printing Office, 1997b.

Center for Substance Abuse Treatment. *Supplementary Administration Manual for the Expanded Female Version of the Addiction Severity Index (ASI) Instrument, The ASI-F*. DHHS Pub. No. (SMA) 96-8056. Rockville, MD: Center for Substance Abuse Treatment, 1997c.

Center for Substance Abuse Treatment. *Comprehensive Case Management for Substance Abuse Treatment*. Treatment Improvement Protocol (TIP) Series, Number 27. DHHS Pub. No. (SMA) 98-3222. Washington, DC: U.S. Government Printing Office, 1998a.

Center for Substance Abuse Treatment. *Continuity of Offender Treatment for Substance Use Disorders From Institution to Community*. Treatment Improvement Protocol (TIP) Series, Number 30. DHHS Pub. No. (SMA) 98-3222. Washington, DC: U.S. Government Printing Office, 1998b.

Center for Substance Abuse Treatment. *Screening and Assessing Adolescents for Substance Use Disorders*. Treatment Improvement Protocol (TIP) Series, Number 31. DHHS Pub. No. (SMA) 99-3282. Washington, DC: U.S. Government Printing Office, 1999a.

Center for Substance Abuse Treatment. *Treatment of Adolescents With Substance Use Disorders.* Treatment Improvement Protocol (TIP) Series, Number 32. DHHS Pub. No. (SMA) 99-3283. Washington, DC: U.S. Government Printing Office, 1999b.

Center for Substance Abuse Treatment. *Enhancing Motivation for Change in Substance Abuse Treatment.* Treatment Improvement Protocol (TIP) Series, Number 35. DHHS Pub. No. (SMA) 99-3354. Washington, DC: U.S. Government Printing Office, 1999c.

Center for Substance Abuse Treatment. *Integrating Substance Abuse Treatment and Vocational Services.* Treatment Improvement Protocol (TIP) Series. Washington DC: U.S. Government Printing Office, in press (a).

Center for Substance Abuse Treatment. *Substance Abuse Treatment for Persons With HIV/AIDS.* Treatment Improvement Protocol (TIP) Series. Washington, DC: U.S. Government Printing Office, in press (b).

Chasnoff, I.J.; Landress, H.J.; and Barrett, M.E. The prevalence of illicit-drug or alcohol use during pregnancy and discrepancies in mandatory reporting in Pinellas County, Florida. *New England Journal of Medicine* 322:1202–1206, 1990.

Chassin, L.; Curran, P.J.; Hussong, A.M.; and Colder, C.R. Relation of parent alcoholism to adolescent substance use: A longitudinal follow-up study. *Journal of Abnormal Psychology* 105:70–80, 1996.

Child Welfare League of America (CWLA). *Standards for Services for Abused or Neglected Children and Their Families.* Washington, DC: CWLA, 1989.

Child Welfare League of America (CWLA). *Children at the Front: A Different View of the War on Alcohol and Drugs.* Washington, DC: CWLA, 1992.

Cicchetti, D., and Lynch, M. Toward an ecological/transactional model of community violence and child maltreatment. *Psychiatry* 5:696–718, 1993.

Cicchetti, D., and Lynch, M. Failures in the expectable environment and their impact on individual development: The case of child maltreatment. In: Cicchetti, D., and Cohen, D.J., eds. *Developmental Psychopathology.* Vol. 2, *Risk, Disorder, and Adaptation.* New York: John Wiley and Sons, 1995. pp. 32–71.

Clark, D.B.; Lesnick, L.; and Hegedus, A.M. Traumas and other adverse life events in adolescents with alcohol abuse and dependence. *Journal of the American Academy of Child and Adolescent Psychiatry* 36(12):1744–1751, 1997.

Clay, R.A. Public backlash buoys antimanaged-care laws. *APA Monitor* 29(3), 1998. http://www.pbs.org.backlash.html [Accessed Jan. 27, 1999].

Coletti, S.; Hamilton, N.; and Donaldson, P. Operation PAR, Inc. PAR Village: Long-term treatment for women and their children: Process evaluation and research findings. In: Goldberg, S.; Barth, R.; and Vogel-Edwards, M., eds. *Service Outcomes for Drug- and HIV-Affected Families.* Berkeley, CA: National Abandoned Infants Assistance Resource Center, 1997. pp. 104–117.

Corey, M.S., and Corey, G. *Groups: Process and Practice,* 5th ed. Pacific Grove, CA: Brooks/Cole Publishing, 1996. pp. 109–126.

Cornell, W.F., and Olio, K.A. Integrating affect in treatment with adult survivors of physical and sexual abuse. *American Journal of Orthopsychiatry* 61(1):59–69, 1991.

Courtney, M.E. The costs of child protection in the context of welfare reform. *Future of Children* 8(1):88–103, 1998.

Courtois, C. *Healing the Incest Wound: Adult Survivors in Therapy*. New York: W.W. Norton, 1988.

Courtois, C. Assessment and diagnosis. In: Classen, C., ed. *Treating Women Molested in Childhood*. San Francisco: Jossey-Bass, 1995. pp. 1–34.

Courtois, C. *Recollections of Sexual Abuse: Treatment Principles and Guidelines*. New York: W.W. Norton, 1999.

Craddock, S.G.; Rounds-Bryant, J.L.; Flynn, P.M.; and Hubbard, R.L. Characteristics and pretreatment behaviors of clients entering drug abuse treatment: 1969 to 1993. *American Journal of Drug and Alcohol Abuse* 23(1):43–59, 1997.

Craine, L.S.; Henson, C.H.; Colliver, J.A.; and MacLean, D.G. Prevalence of a history of sexual abuse among female psychiatric clients in a State hospital system. *Hospital and Community Psychiatry* 39:300–304, 1988.

Daley, D.C.; Moss, H.B.; and Campbell, F. *Dual Disorders: Counseling Clients with Chemical Dependency and Mental Illness*, 2nd ed. Center City, MN: Hazelden Foundation, 1993.

Daro, D., and McCurdy, K. "Current trends in child abuse reporting and fatalities: The results of the 1990 Annual Fifty State Surveys." Unpublished paper, National Committee for Prevention of Child Abuse, 1991.

Davis, N.; Custer, K.; Bethea-Jackson, G.; Marcey, M.; and Watson, B. *Once Upon a Time: Therapeutic Stories To Heal Abused Children*, rev. ed. Oxon Hill, MD: Nancy Davis, 1990.

Davis, S.K. Chemical dependency in women: A description of its effects and outcomes on adequate parenting. *Journal of Substance Abuse Treatment* 7:225–232, 1990.

De Bellis, M.D. Posttraumatic stress disorder and acute stress disorder. In: Ammerman, R.T., and Hersen, M., eds. *Handbook of Prevention and Treatment With Children and Adolescents: Intervention in the Real World Context*. New York: John Wiley and Sons, 1997.

De Bellis, M.D., and Putnam, F.W. The psychobiology of childhood maltreatment. *Child and Adolescent Psychiatric Clinics of America* 3(4):663–678, 1994.

Della Femina, D.; Yeager, C.A.; and Lewis, D.O. Child abuse: Adolescent records vs. adult recall. *Child Abuse and Neglect* 14:227–231, 1990.

Demaré, D. "The childhood maltreatment questionnaire." Unpublished manuscript. University of Manitoba, Winnipeg, MB, 1993.

Dembo, R.; Williams, L.; LaVoie, L.; Berry, E.; Getreu, A.; Wish, E.; Schmeidler, J.; and Washburn, M. Physical abuse, sexual victimization, and illicit drug use: Replication of a structural analysis among a new sample of high-risk youths. *Violence and Victims* 4(2):121–138, 1989.

DePanfilis, D., and Salus, M.K. *A Coordinated Response to Child Abuse and Neglect: A Basic Manual*. National Center on Child Abuse and Neglect. DHHS Pub. No. (ACF) 92-30362. Washington, DC: U.S. Government Printing Office, 1992.

Derogatis, L.R. *Brief Symptom Inventory (BSI): Administration, Scoring, and Procedures Manual*, 2nd ed. Baltimore: Clinical Psychometric Research, 1992.

Derogatis, L.R. *Symptom Checklist-90-R (SCL-90-R): Administration, Scoring, and Procedures Manual*, 3rd ed. Minneapolis, MN: National Computer Systems, 1994.

Derogatis, L.R.; Lipman, R.; and Covi, L. SCL-90: An outpatient psychiatric rating scale: Preliminary report. *Psychopharmacology Bulletin* 9(17):13–28, 1973.

Derogatis, L.R., and Spencer, P.M. *Administration and Procedures: BSI Manual-I, Clinical Psychometric Research.* Baltimore: Johns Hopkins University School of Medicine, 1982.

Devore, W., and Schlesinger, E.G. *Ethnic-Sensitive Social Work Practice.* Columbus, OH: Merrill Publishing Company, 1987.

Deykin, E.Y.; Buka, S.L.; and Zeena, T.H. Depressive illness among chemically dependent adolescents. *American Journal of Psychiatry* 149(10):1341–1347, 1992.

Dion, M.R.; Braver, S.L.; Wolchik, S.A.; and Sandler, I.N. Alcohol abuse and psychopathic deviance in noncustodial parents as predictors of child-support payment and visitation. *American Journal of Orthopsychiatry* 67:70–79, 1997.

Downs, W.R., and Miller, B.A. Intergenerational links between childhood abuse and alcohol-related problems. In: Harrison, L., ed. *Alcohol Problems in the Community.* London: Routledge, 1996. pp. 14–51.

Dukma, L.E., and Roosa, M.W. Role of stress and family relationships in mediating problem drinking and fathers' personal adjustment. *Journal of Studies on Alcoholism* 56:528–537, 1995.

Duncan, F. Prevention issues: Some cautionary notes. In: Hampton, R; Senatore, V.; and Gullotta, T., eds. *Substance Abuse, Family Violence, and Child Welfare: Bridging Perspectives.* Thousand Oaks, CA: Sage Publications, 1998. pp. 249–262.

Dunn, G.E.; Paolo, A.M.; Ryan, J.J.; and Van Fleet, J. Dissociative symptoms in a substance abuse population. *American Journal of Psychiatry* 150(7):1043–1047, 1993.

Dunn, G.E.; Ryan, J.J.; Paolo, A.M.; and Van Fleet, J. Comorbidity of dissociative disorders among patients with substance use disorders. *Psychiatric Services* 46(2):153–156, 1995.

Dutton, D.G. *The Batterer: A Psychological Profile.* New York: BasicBooks, 1995.

Edwall, G.E., and Hoffman, N.G. Correlates of incest reported by adolescent girls in treatment for substance abuse. In: Walker, L., ed. *Handbook on Sexual Abuse of Children: Assessment and Treatment Issues.* New York: Springer Publishing, 1987. pp. 94–106.

Edwall, G.E.; Hoffman, N.G.; and Harrison, P.A. Psychological correlates of sexual abuse in adolescent girls in chemical dependency treatment. *Adolescence* 24(94):279–288, 1989.

Egami, Y.; Ford, D.E.; Greenfield, S.F.; and Crum, R.M. Psychiatric profile and sociodemographic characteristics of adults who report physically abusing or neglecting children. *American Journal of Psychiatry* 153:921–928, 1996.

Elliott, D.M., and Briere, J. Sexual abuse trauma among professional women: Validating the Trauma Symptom Checklist-40 (TSC-40). *Child Abuse and Neglect* 16(3):391–398, 1992.

Erikson, E.H. *Identity and the Life Cycle.* New York: W.W. Norton, 1980.

Evans, K., and Sullivan, J.M. *Treating Addicted Survivors of Trauma.* New York: Guilford Press, 1995.

Falsetti, S.A.; Resnick, H.S.; Resnick, P.A.; and Kilpatrick, D. The modified PTSD Symptom Scale: A brief self-report measure of posttraumatic stress disorder. *The Behavioral Therapist* 16:161–162, 1993.

Famularo, R.; Kinscherff, R.; and Fenton, T. Parental substance abuse and the nature of child maltreatment. *Child Abuse and Neglect* 16:475–483, 1992.

Farrants, J. The "false memory" debate: A critical review of the research on recovered memories of child sexual abuse. *Counseling Psychology Quarterly* 11(3):229–238, 1998.

Feig, L. Understanding the problem: The gap between substance abuse programs and child welfare services. In: Hampton, R.L.; Senatore, V.; and Gullota, T.P., eds. *Substance Abuse, Family Violence, and Child Welfare: Bridging Perspectives.* Thousand Oaks, CA: Sage Publications, 1998. pp. 62–95.

Feig, L., and McCullough, C. The role of child welfare. In: Haack, M.R., ed. *Drug-Dependent Mothers and Their Children.* New York: Springer Publishing, 1997. pp. 215–235.

Felitti, V.J. Long-term medical consequences of incest, rape, and molestation. *Southern Medical Journal* 84(3):328–331, 1991.

Felitti, V.J.; Anda, R.F.; Nordenberg, D.; Williamson, D.F.; Spitz, A.M.; Edwards, V.; Koss, M.P.; and Marks, J.S. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine* 14(4):245–258, 1998.

Figley, C. *Compassion Fatigue: Coping With Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized.* New York: Brunner/Mazel, 1995.

Figueroa, C.; Anda, R.; Whitfield, C.L.; Felitti, V.; Nordenberg, D.; Edwards, V.; Malarcher, A.; and Sharp, D. Sexual abuse as a risk factor for smoking, substance abuse, and attempted suicide for boys and girls. Manuscript submitted for publication.

Fink, L.A.; Bernstein, D.; Handelsman, L.; Foote, J.; and Lovejoy, M. Initial reliability and validity of the childhood trauma interview: A new multidimensional measure of childhood interpersonal trauma. *American Journal of Psychiatry* 152(9):1329–1335, 1995.

Finkelhor, D. The trauma of child sexual abuse: Two models. *Journal of Interpersonal Violence* 2:348–366, 1987.

Finkelhor, D. Epidemiological factors in the clinical identification of child sexual abuse. *Child Abuse and Neglect* 17(1):67–70, 1993.

Finkelhor, D. Current information on the scope and nature of child sexual abuse. *Future of Children* 4(2):31–53, 1994.

Finkelhor, D.; Gelles, R.J.; Hotaling, G.T.; and Strauss, M.A., eds. *The Dark Side of Families: Current Family Violence Research.* Beverly Hills, CA: Sage Publications, 1983.

Finkelhor, D.; Hotaling, G.; Lewis, I.A.; and Smith, C. Sexual abuse in a national survey of adult men and women: Prevalence, characteristics, and risk factors. *Child Abuse and Neglect* 14(1):19–28, 1990.

First, M.B.; Gibbon, M.; Spitzer, R.L.; and Williams, J.B.W. *Structured Clinical Interview for DSM-IV Axis I Disorders (SCIDI): Clinician Version.* Washington, DC: American Psychiatric Press, 1997.

Foa, E. *Posttraumatic Diagnostic Scale Manual.* Minneapolis, MN: National Computer Systems, 1996.

Foa, E.; Cashman, L.; Jaycox L.; and Perry, K. The validation of a self-report measure of PTSD: The Posttraumatic Diagnostic Scale (PDS). *Psychological Assessment*, in press.

Fontana, V.J., and Besharov, D.J. *The Maltreated Child*, 4th ed. Springfield, IL: Charles C. Thomas Publishing, 1979.

French, G.D., and Gerbode, F.A. *The Traumatic Incident Reduction Workshop*, 2nd ed. Menlo Park, CA: IRM Press, 1993.

Funk, J.B. Management of sexual molestation in preschoolers. *Clinical Pediatrics (Phila)* 19(10):686–688, 1980.

Fureman, B.; Parikh, G.; Bragg, A.; and McLellan, A.T. *Addiction Severity Index: A Guide to Training and Supervising ASI Interviewers*, 5th ed. Philadelphia: University of Pennsylvania and Veterans Administration Center for Studies of Addiction, 1990.

Garbarino, J. The human ecology of child maltreatment. *Journal of Marriage and the Family* 39:721–735, 1977.

Garbarino, J., and Gilliam, G. *Understanding Abusive Families*. Lexington, MA: Lexington Books, 1980.

Garbarino, J.; Guttmann, E.; and Seeleya, J. *The Psychologically Battered Child*. San Francisco: Jossey-Bass, 1986.

Garrity-Rokous, F.E. Punitive legal approaches to the problem of prenatal drug exposure. *Infant Mental Health Journal* 15(2):208–237, 1994.

General Accounting Office. *Juvenile Courts: Reforms Aim To Better Serve Maltreated Children*. Pub. No. GAO/HEHS-99-13. Washington, DC: U.S. Government Printing Office, 1999.

Gerard, A.B. *Parent-Child Relationship Inventory (PCRI): Manual*. Los Angeles: Western Psychological Services, 1994.

Gerstein, D.R.; Johnson, R.A.; Larison, C.L.; Harwood, H.J.; and Fountain, D. *Alcohol and Other Drug Treatment for Parents and Welfare Recipients: Outcomes, Costs, and Benefits*. Washington, DC: U.S. Department of Health and Human Services, 1997.

Gerstein, D.R.; Johnson, R.A.; Larison, C.L.; Harwood, H.J.; and Fountain, D. *Alcohol and Other Drug Treatment for Parents and Welfare Recipients: Outcomes, Costs, and Benefits*. Washington, DC: U.S. Department of Health and Human Services, 1998.

Gilliland, B., and James, R. *Crisis Intervention Strategies*. Pacific Grove, CA: Brooks/Cole, 1988.

Giovannoni, J.M., and Becerra, R.M. *Defining Child Abuse*. New York: Free Press, 1979.

Giovannoni, J.M., and Billingsley, A. Child neglect among the poor: A study of parental inadequacy in families of three ethnic groups. *Child Welfare* 49:196–204, 1970.

Glover, N.M.; Janikowski, T.P.; and Benshoff, J.J. Substance abuse and past incest contact: A national perspective. *Journal of Substance Abuse Treatment* 13(3):185–193, 1996.

Goerge, R.; Wulczyn, F.; and Harden, A. New comparative insights into States and their foster children. *Public Welfare* 54(3):12–25, 1996.

Gomes-Schwartz, B.; Horowitz, J.M.; and Sauzier, M. Severity of emotional distress among sexually abused preschool, school-age, and adolescent children. *Hospital and Community Psychiatry* 36(5):503–508, 1985.

Gould, J. A psychometric investigation of the standard and short form Beck Depression Inventory. *Psychological Reports* 51(3 pt 2):1167–1170, 1982.

Greening, T. Posttraumatic stress disorder: An existential-humanistic perspective. In: Krippner, S., and Powers, S.M., eds. *Broken Images, Broken Selves: Dissociative Narratives in Clinical Practice.* Washington, DC: Brunner/Mazel, 1997. pp. 125–135.

Grice, D.; Brady, K.; Dustan, L.; Malcolm, R.; and Kilpatrick, D. Sexual and physical assault history and posttraumatic stress disorder in substance-dependent individuals. *American Journal of Addictions* 4(4):297–305, 1995.

Grosch, W.N., and Olsen, D.C. *When Helping Starts To Hurt: A New Look at Burnout Among Psychotherapists.* New York: W.W. Norton, 1994.

Gross, A.B., and Keller, H.R. Long-term consequences of childhood physical and psychological maltreatment. *Aggressive Behavior* 18:171–185, 1992.

Grossman, J., and Schottenfeld, R. Pregnancy and women's issues. In: Kosten, T.R., and Kleber, H.D., eds. *Clinician's Guide to Cocaine Addiction: Theory, Research, and Treatment.* New York: Guilford Press, 1992. pp. 374–388.

Gurvitz, T.V.; Shenton, M.E.; and Pitman, R.K. "Reduced hippocampal volume on magnetic resonance imaging in chronic post-traumatic stress disorder." Paper presented at the annual meeting of the International Society for Traumatic Stress Studies, Miami, FL, 1995.

Gussman, F.; Stewart, J.; Young, B.; Riney, S.; Abueg, F.; and Blake, D. A multicultural developmental approach for treating trauma. In: Marsella, A.; Friedman, M.; Gerrity, E.; and Scurfield, R., eds. *Ethnocultural Aspects of Posttraumatic Stress Disorder: Issues, Research, and Clinical Applications.* Washington, DC: American Psychological Association, 1996. pp. 439–457.

Gutierres, S.E.; Russo, N.F.; and Urbanski, L. Sociocultural and psychological factors in American Indian drug use: Implications for treatment. *International Journal of the Addictions* 29(14):1761–1786, 1994.

Gutierres, S.E., and Todd, M. Impact of childhood abuse on treatment outcomes of substance users. *Professional Psychology: Research and Practice* 28(4):348–354, 1997.

Hammarberg, M. Penn Inventory for Posttraumatic Stress Disorder: Psychometric properties. *Psychological Assessment* 4:67–76, 1992.

Hammarberg, M. Psychometric review of the Penn Inventory for Post Traumatic Stress Disorder. In: Stamm, B.H., ed. *Measurement of Stress, Trauma, and Adaptation.* Lutherville, MD: Sidran Press, 1996. pp. 231–235.

Hansen, M., and Harway, M., eds. *Battering and Family Therapy: A Feminist Perspective.* Newbury Park, CA: Sage Publications, 1993.

Harrison, J.B., and Morris, L.A. Group therapy for adult male survivors of childhood sexual abuse. In: Andronico, M.P., ed. *Men in Groups: Insight, Interventions, and Psychoeducational Work.* Washington, DC: American Psychological Association, 1996. pp. 339–356.

Harrison, P.A.; Hoffman, N.G.; and Edwall, G.E. Differential drug use patterns among sexually abused adolescent girls in treatment for chemical dependency. *International Journal of the Addictions* 24:499–514, 1989a.

Harrison, P.A.; Hoffman, N.G.; and Edwall, G.E. Sexual abuse correlates: Similarities between male and female adolescents in chemical dependency treatment. *Journal of Adolescent Research* 4(3):385–399, 1989b.

Hasin, D.S.; Grant, B.F.; Glick, H.R.; and Endicott, J. *The Psychiatric Research Interview for Substance and Mental Health Disorders.* New York: Department of Research Training, New York State Psychiatric Institute, 1992.

Hasin, D.S.; Trautman, K.D.; Miele, G.M.; Samet, S.; Smith, M.; and Endicott, J. Psychiatric Research Interview for Substance and Mental Disorders (PRISM): Reliability for substance abusers. *American Journal of Psychiatry* 153(3):1195–1201, 1996.

Haver, B. Female alcoholics: IV. The relationship between family violence and outcome 3–10 years after treatment. *Acta Psychiatrica Scandinavica* 75(5):449–455, 1987.

Hawley, T., and Disney, E. Crack's children: The consequences of maternal cocaine abuse. *Social Policy Report: Society for Research in Child Development* 6(4):1–23, 1992.

Hayek, M.A. "Recovered Alcoholic Women With and Without Incest Experience: A Comparative Study." Ph.D. dissertation, Heed University, Hollywood, FL, 1980.

Helfer, M.E., and Kempe, R.S., eds. *The Battered Child,* 5th ed. Chicago: University of Chicago Press, 1997.

Herman, J.L. *Trauma and Recovery.* New York: BasicBooks, 1992.

Herman, J.L. Sequelae of prolonged and repeated trauma: Evidence for a complex posttraumatic syndrome (DESNOS). In: Davidson, J., and Foa, E., eds. *Post-Traumatic Stress Disorder: DSM-IV and Beyond.* Washington, DC: American Psychiatric Press, 1993. pp. 213–228.

Herman, J.L.; Perry, J.C.; and van der Kolk, B.A. Childhood trauma in borderline personality disorder. *American Journal of Psychiatry* 146(4):490–495, 1989.

Hien, D.A., and Levin, F.R. Trauma and trauma-related disorders for women on methadone: Prevalence and treatment considerations. *Journal of Psychoactive Drugs* 26(4):421–429, 1994.

Hien, D.A., and Scheier, J. Trauma and short-term outcome for women in detoxification. *Journal of Substance Abuse Treatment* 13(3):227–231, 1996.

Holmes, G.R.; Offen, L.; and Waller, G. See no evil, hear no evil, speak no evil: Why do relatively few male victims of childhood sexual abuse receive help for abuse-related issues in adulthood? *Clinical Psychology Review* 17(1):69–88, 1997.

Holmes, W.C., and Slap, G.B. Sexual abuse of boys: Definition, prevalence, correlates, sequelae, and management. *JAMA* 280(21):1855–1862, 1998.

Horowitz, M.J. *Stress Response Syndromes.* New York: Jason Aronson, 1976.

Howard, J. Client-oriented prevention strategies and programs: Pregnant women and their newborns. In: Coombs, R.H., and Ziedonis, D., eds. *Handbook on Drug Abuse Prevention: A Comprehensive Strategy to Prevent the Abuse of Alcohol and Other Drugs.* Boston: Allyn and Bacon, 1995. pp. 337–359.

Hunter, M. *Abused Boys: The Neglected Victims of Sexual Abuse.* Lexington, MA: Lexington Books, 1990.

Hurley, D.L. Incest and the development of alcoholism in adult female survivors. *Alcoholism Treatment Quarterly* 7(2):41–56, 1990.

Ichiyama, M.A.; Zucker, R.A.; Fitzgerald, H.E.; and Bingham, C.R. Articulating subtype differences in self and relational experience among alcoholic men using structural analysis of social behavior. *Journal of Consulting and Clinical Psychology* 64:1245–1254, 1996.

Ireland, T., and Widom, C.S. Childhood victimization and risk for alcohol and drug arrests. *International Journal of the Addictions* 29(2):235–274, 1994.

Janikowski, T.P., and Glover, N.M. Incest and substance abuse: Implications for treatment professionals. *Journal of Substance Abuse Treatment* 11(3):177–183, 1994.

Jarvis, T.J.; Copeland, J.; and Walton, L. Exploring the nature of the relationship between child sexual abuse and substance use among women. *Addiction* 93(6):865–875, 1998.

Justice, B., and Duncan, D.F. Physical abuse of children as a public health problem. *Public Health Reviews* 4(2):183–200, 1975.

Kahn, M. *Between Therapist and Client: The New Relationship.* New York: W.H. Freeman and Co., 1991.

Kalichman, S.C. *Mandated Reporting of Suspected Child Abuse: Ethics, Law, and Policy.* Washington, DC: American Psychological Association, 1993.

Kaufman, J., and Zigler, E. Do abused children become abusive parents? *American Journal of Orthopsychiatry* 57(2):186–192, 1987.

Kearney, M.; Murphy, S.; and Rosenbaum, M. Mothering on crack cocaine: A grounded theory analysis. *Social Science and Medicine* 38(2):351–361, 1994.

Kempe, C.H., and Helfer, R.E. *Helping the Battered Child and His Family.* Philadelphia: Lippincott, 1972.

Killeen, T.K.; Brady, K.T.; and Thevos, A. Addiction severity, psychopathology and treatment compliance in cocaine-dependent mothers. *Journal of Addictive Diseases* 14:75–84, 1995.

Klerman, G. L. *Interpersonal Psychotherapy of Depression.* New York: BasicBooks, 1984.

Klerman, G.L., and Weissman, M.M., eds. *New Applications of Interpersonal Psychotherapy.* Washington, DC: American Psychiatric Press, 1993.

Kovach, J.A. "The Relationship Between Treatment Failures of Alcoholic Women and Incestuous Histories With Possible Implications for Posttraumatic Stress Disorder Symptomatology." Ph.D. dissertation, Wayne State University, Detroit, MI, 1983.

Krinsley, K.E. Psychometric review of the Evaluation of Lifetime Stressors (ELS) questionnaire and interview. In: Stamm, B.H., ed. *Measurement of Stress, Trauma, and Adaptation.* Lutherville, MD: Sidran Press, 1996. pp. 160–162.

Krinsley, K.E.; Brief, D.J.; Weathers, F.W.; and Steinberg, H.R. "Problems associated with childhood trauma in substance abusers." Poster presented at the annual meeting of the Association for Advancement of Behavior Therapy, San Diego, CA, 1994.

Krinsley, K.E.; Gallagher, J.H.; Weathers, F.W.; Kaloupek, D.G.; and Vielhauer, M. "Reliability and validity of the Evaluation of Lifetime Stressors questionnaire." Unpublished manuscript, 1997.

Krinsley, K.E.; Young, L.S.; Weathers, F.W.; Brief, D.J.; and Kelley, J.M. "Behavioral correlates of childhood trauma in substance abusing men." Poster presented at the annual meeting of the Association for Advancement of Behavior Therapy, Boston, MA, 1992.

Kroll, P.D.; Stock, D.F.; and James, M.E. The behavior of adult alcoholic men abused as children. *Journal of Nervous and Mental Disease* 173(11):689–693, 1985.

Kropenske, V., and Howard, J. *Protecting Children in Substance-Abusing Families: The User Manual Series.* Washington, DC: U.S. Department of Health and Human Services, National Center on Child Abuse and Neglect, 1994.

Krugman, S. Men's shame and trauma in therapy. In: Pollack, W.S., and Levant, R.F., eds. *New Psychotherapy for Men.* New York: John Wiley and Sons, 1998. pp. 167–190.

Kufeldt, K., and Nimmo, M. Youth on the street: Abuse and neglect in the eighties. *Child Abuse and Neglect* 11:531–543, 1987.

Kumpfer, K.L.; Molraard, V.; and Spoth, R. The Strengthening Families Program for the prevention of delinquency and drug use. In: Peters, R.D., and McMahon, R.J., eds. *Preventing Childhood Disorders, Substance Abuse, and Delinquency.* Thousand Oaks, CA: Sage Publications, 1996. pp. 249–267.

Kuyken, W., and Brewin, C.R. Intrusive memories of childhood abuse during depressive episodes. *Behavior Research and Therapy* 32:525–528, 1994.

LaCoursiere, R.B. Diverse motives for fictitious post-traumatic stress disorder. *Journal of Traumatic Stress* 6(1):141–149, 1993.

Lammers, S.M.; Schippers, G.M.; and van der Staak, C.P. "Functionality of drinking in alcohol dependent women who report sexual abuse." Poster presented at the Seventh International Conference on the Treatment of Addictive Behaviors, Leeuvenhoorst, the Netherlands, 1995.

Landrine, H., and Klonoff, E.A. The schedule of racist events: A measure of racial discrimination and a study of its negative physical and mental health consequences. *Journal of Black Psychology* 22:144–168, 1996.

Landry, M. *Understanding Drugs of Abuse: The Processes of Addiction, Treatment, and Recovery.* Washington, DC: American Psychiatric Press, 1994.

Langeland, W., and Hartgers, C. Child sexual and physical abuse and alcoholism: A review. *Journal of Studies on Alcohol* 59(3):336–348, 1998.

Leber, W.R.; Jenkins, R.L.; and Parsons, O.A. Recovery of visual-spatial learning and memory in chronic alcoholics. *Journal of Clinical Psychology* 37(1):192–197, 1981.

Lerner, H.G. *Women in Therapy: Devaluation, Anger, Aggression, Depression, Self-Sacrifice, Mothering, Mother Blaming, Self-Betrayal, Sex-Role Stereotypes, Dependency, Work and Success Inhibitions.* New York: Jason Aronson, 1988.

Levey, S.J., and Rutter, E. *Children of Drug Abusers.* New York: Lexington Books, 1992.

Linehan, M.M. *Cognitive–Behavioral Treatment of Borderline Personality Disorder.* New York: Guilford Press, 1993a.

Linehan, M.M. *Skills Training Manual for Treating Borderline Personality Disorder.* New York: Guilford Press, 1993b.

Loftus, E.F. The reality of repressed memories. *American Psychologist* 48(5):518–537, 1993.

Loftus, E.F. Memory distortion and false memory creation. *Bulletin of the American Academy of Psychiatry and the Law* 24(3):281–295, 1996.

Luthar, S.S., and Suchman, N.E. Developmentally informed parenting interventions: The Relational Psychotherapy Mothers' Group. In: Cicchetti, D., and Toth, S., eds. *Rochester Symposium on Developmental Psychopathology.* Vol. 10, *Developmental Approaches to Prevention and Intervention.* Rochester, NY: University of Rochester Press, 1999. pp. 271–310.

Luthar, S.S., and Suchman, N.E. Relational Psychotherapy Mothers' Group: A developmentally informed intervention for at-risk mothers. *Development and Psychopathology,* in press.

Luthar, S.S., and Walsh, K.G. Treatment needs of drug-addicted mothers. Integrated parenting psychotherapy interventions. *Journal of Substance Abuse Treatment* 12(5):341–348, 1995.

Mackay, P.W., and Marlatt, G.A. Maintaining sobriety: Stopping is starting. *International Journal of the Addictions* 25:1257–1276, 1990–1991.

MacMillan, H.L.; Fleming, J.E.; Trocmé, N.; Boyle, M.H.; Wong, M.; Racine, Y.A.; Beardslee, W.R.; and Offord, D.R. Prevalence of child physical and sexual abuse in the community: Results from the Ontario Health Supplement. *JAMA* 278:131–135, 1997.

Magura, S., and Laudet, A.B. Parental substance abuse and child maltreatment: Review and implications for intervention. *Children and Youth Services Review* 18(3):193–220, 1996.

Malinosky-Rummell, R., and Hansen, D.J. Long-term consequences of childhood physical abuse. *Psychological Bulletin* 114(1):68–79, 1993.

Manson, S.M. Cross-cultural and multiethnic assessment of trauma. In: Wilson, W.J., and Keane, T.M., eds. *Assessing Psychological Trauma and PTSD.* New York: Guilford Press, 1997. pp. 239–266.

Marlatt, G.A., and Gordon, J.R., eds. *Relapse Prevention: Maintenance Strategies in the Treatment of Addictive Behaviors.* New York: Guilford Press, 1985.

Mayes, L.C.; Feldman, R.; Granger, R.H.; Haynes, O.M.; Bornstein, M.H.; and Schottenfeld, R. The effects of polydrug use with and without cocaine on mother–infant interaction at 3 and 6 months. *Infant Behavior and Development* 20(4):489–502, 1997.

McClain, P.W.; Sack, J.J.; Froehlke, R.G.; and Ewigman, B.G. Estimates of fatal child abuse and neglect, United States, 1979 through 1988. *Pediatrics* 91:338–343, 1993.

McCord, J. A forty-year perspective on effects of child abuse and neglect. *Child Abuse and Neglect* 7:265–270, 1983.

McCurdy, K., and Daro, D. *Current Trends in Child Abuse Reporting and Fatalities: The Results of the 1993 Annual Fifty State Survey.* Chicago: National Committee for Prevention of Child Abuse, 1994.

McGee, R.A., and Wolfe, D.A. Psychological maltreatment: Toward an operational definition. *Development and Psychopathology* 3:3–18, 1991.

McLellan, A.T.; Parikh, G.; Bragg, A.; Cacciola, J.; Fureman, B.; and Incmikoski, R. *Addiction Severity Index: Administration Manual.* Philadelphia: University of Pennsylvania and Veterans Administration Center for Studies of Addiction, 1990.

McMahon, T.J., and Luthar, S.S. Bridging the gap for children as their parents enter substance abuse treatment. In: Hampton, R.L.; Senatore, V.; and Gullota, T.P., eds. *Substance Abuse, Family Violence, and Child Welfare: Bridging Perspectives.* Thousand Oaks, CA: Sage Publications, 1998. pp. 143–187.

McNair, D.M.; Lorr, M.; and Droppleman, L.F. *EdITS Manual for the Profile of Mood States.* San Diego, CA: Educational and Industrial Testing Service, 1992.

Melton, G.B.; Goodman, G.S.; Kalichman, S.C.; Levine, M.; Saywitz, K.J.; and Koocher, G.P. Empirical research on child maltreatment and the law. *Journal of Clinical Child Psychology* 24(Suppl):47–77, 1995.

Metsch, L.R.; Rivers, J.E.; Miller, M.; Bohs, R.; McCoy, C.B.; Morrow, C.J.; Bandstra, E.S.; Jackson, V.; and Gissen, M. Implementation of a family-centered treatment program for substance-abusing women and their children: Barriers and resolutions. *Journal of Psychoactive Drugs* 27(1):73–83, 1995.

Miller, B.A., and Downs, W.R. Violent victimization among women with alcohol problems. *Recent Developments in Alcoholism* 12:81–101, 1995.

Miller, B.A.; Downs, W.R.; and Testa, M. Interrelationships between victimization experiences and women's alcohol use. *Journal of Studies on Alcohol* 11:109–117, 1993.

Miller, B.A.; Maguin, E.; and Downs, W.R. Alcohol, drugs, and violence in children's lives. *Recent Developments in Alcoholism* 13:357–385, 1997.

Miller, W.R.; Brown, J.M.; Simpson, T.L.; Handmaker, N.S.; Bien, T.H.; Luckie, L.F.; Montgomery, H.A.; Hester, R.K.; and Tonigan, J.S. What works? A methodological analysis of the alcohol treatment outcome literature. In: Hester, R.K., and Miller, W.R., eds. *Handbook of Alcoholism Treatment Approaches,* 2nd ed. Boston: Allyn and Bacon, 1995a.

Miller, W.R., and Sovereign, R.G. The Check-up: A model for early intervention in addictive behaviors. In: Løberg, T.; Miller, W.R.; Nathan, P.E.; and Marlatt, G.A., eds. *Addictive Behaviors: Prevention and Early Intervention.* Amsterdam: Swets and Zeitlinger, 1989. pp. 219–231.

Miller, W.R.; Taylor, C.A.; and West, J.C. Focused versus broad-spectrum behavior therapy for problem drinkers. *Journal of Consulting and Clinical Psychology* 48(5):590–601, 1980.

Miller, W.R.; Tonigan, J.S.; and Longabaugh, R. *The Drinker Inventory of Consequences (DrInC): An Instrument for Assessing Adverse Consequences of Alcohol Abuse.* Test Manual, Project MATCH Monograph Series, Vol. 4. Rockville, MD: National Institute on Alcohol Abuse and Alcoholism, 1995b.

Mokuau, N., ed. *Handbook of Social Services for Asian and Pacific Islanders.* New York: Greenwood Press, 1991.

Mumm, A.M.; Olsen, L.J.; and Allen, D. Families affected by substance abuse: Implications for generalist social work practice. *Families in Society* 79(4):384–394, 1998.

Najavits, L.M.; Weiss, R.D.; Reif, S.; Gastfriend, D.R.; Siqueland, L.; Barber, J.P.; Butler, S.F.; Thase, M.; and Blaine, J. The addiction severity index as a screen for trauma and posttraumatic stress disorder. *Journal of Studies on Alcohol* 59(1):56–62, 1998.

National Association of Alcoholism and Drug Abuse Counselors (NAADAC). *Counselors' Ethical Standards of Alcoholism and Drug Abuse Counselors.* http://www.naadac.org/ethics.htm [Accessed Sept. 9, 1999].

National Center on Child Abuse and Neglect. *Child Maltreatment 1995: Reports From the States to the National Center on Child Abuse and Neglect.* Washington, DC: U.S. Government Printing Office, 1997.

National Center on Child Abuse and Neglect. *National Child Abuse and Neglect Statistical Fact Sheet.* http://www.calib.com.80/nccanch/pubs/statinfo/stats.htm [Accessed July 15, 1999].

National Institute on Drug Abuse. *Assessing Client Needs Using the Addiction Severity Index: Resource Manual.* NIH Pub. No. 93-3620. Rockville, MD: National Institute on Drug Abuse, 1993.

National Institute on Drug Abuse. *Substance Abuse Among Women and Parents.* Washington, DC: U.S. Government Printing Office, 1994.

National Research Council. *Understanding Child Abuse and Neglect.* Washington, DC: National Academy Press, 1993.

Neisen, J.H., and Sandall, H. Alcohol and other drug abuse in a gay/lesbian population: Related to victimization? *Journal of Psychology and Human Sexuality* 3:151–168, 1990.

Neumann, D.A.; Houskamp, B.M.; Pollock, V.E.; and Briere, J. The long-term sequelae of childhood sexual abuse in women: A meta-analytic review. *Child Maltreatment* 1:6–16, 1996.

Newman, E.; Kaloupek, D.G.; and Keane, T.M. Assessment of posttraumatic stress disorder in clinical and research settings. In: van der Kolk, B.A.; McFarlane, A.C.; and Weisaeth, L., eds. *Traumatic Stress: The Effects of Overwhelming Experiences on Mind, Body, and Society.* New York: Guilford Press, 1996. pp. 242–275.

Ney, P.G.; Fung, T.; and Wickett, A.R. Child neglect: The precursor to child abuse. *Pre- and Perinatal Psychology Journal* 8:95–112, 1993.

Ney, P.G.; Fung, T.; and Wickett, A.R. The worst combinations of child abuse and neglect. *Child Abuse and Neglect* 18(9):705–714, 1994.

Nyman, G.; Harbin, H.; Book, J.; Wiegand, D.; Lizanich-Aro, S.; Krajewski, T.; Yuhas, M.; and Shoffeitt, P. Green Spring criteria for medical necessity of outpatient treatment and its use in a mental health utilization review program. *Quality Assurance Utilization Review* 7(2):65–69, 1992.

Olsen, L.J. Services for substance abuse-affected families: The Project Connect experience. *Child and Adolescent Social Work Journal* 12(3):183–195, 1995.

Ostendorf, C.G. "Alcohol Abuse: An Alternative to Dissociation as a Psychological Coping Strategy of Adult Female Incest Survivors." Ph.D. dissertation, University of Wisconsin, Milwaukee, 1995. Abstract in *Dissertation Abstracts International* 57(2):591–A, 1995.

Ouimette, P.C.; Wolfe, J.; and Chrestman, K.R. Characteristics of posttraumatic stress disorder—Alcohol abuse comorbidity in women. *Journal of Substance Abuse* 8(3):335–346, 1996.

Palmer, J.A.; Palmer, L.K.; Williamson, D.; Michiels, K.; and Thigpen, B. Childhood abuse as a factor in attrition from drug rehabilitation. *Psychological Reports* 76(3 Pt 1):879–882, 1995.

Paone, D.; Chavkin, W.; Willets, I.; Friedmann, P.; and des Jarlais, D. The impact of sexual abuse: Implications for drug treatment. *Journal of Women's Health* 1:149–153, 1992.

Paradise, J.E.; Rose, L.; Sleeper, L.A.; and Nathanson, M. Behavior, family function, school performance, and predictors of persistent disturbance in sexually abused children. *Pediatrics* 93(3):452–459, 1994.

Pearce, E., and Lovejoy, F. The development and testing of a diagnostic scale for incest survivors. *Journal of Social Psychology* 134(5):677–679, 1994.

Pearce, E., and Lovejoy, F. Detecting a history of childhood sexual experiences among women substance abusers. *Journal of Substance Abuse Treatment* 12:283–287, 1995.

Pearlman, L.A., and Saakvitne, K.W. *Trauma and the Therapist: Countertransference and Vicarious Traumatization in Psychotherapy With Incest Survivors.* New York: W.W. Norton, 1995.

Peck, S. *The Road Less Traveled.* New York: Simon and Schuster, 1981.

Peterson, L.; Gable, S.; and Saldana, L. Treatment of maternal addiction to prevent child abuse and neglect. *Addictive Behaviors* 21(6):789–801, 1996.

Peterson, M.S., and Urquiza, A.J. *The Role of Mental Health Professionals in the Prevention and Treatment of Child Abuse and Neglect.* Washington, DC: National Center on Child Abuse and Neglect, Department of Health and Human Services, 1993.

Polansky, N.; Chalmers, M.A.; Buttenwieser, E.; and Williams, D.P. *Damaged Parents: An Anatomy of Child Neglect.* Chicago: University of Chicago Press, 1981.

Pollock, C., and Steele, B. A therapeutic approach to the parents. In: Kempe, C.H., and Helfer, R.E., eds. *Helping the Battered Child and His Family.* Philadelphia: Lippincott, 1972. pp. 3–21.

Pollock, V.E.; Briere, J.; Schneider, L.; Knop, J.; Mednick, S.A.; and Goodwin, D.W. Childhood antecedents of antisocial behavior: Parental alcoholism and physical abusiveness. *American Journal of Psychiatry* 147(10):1290–1293, 1990.

Polusny, M.A., and Follette, V.M. Long-term correlates of child sexual abuse: Theory and review of the empirical literature. *Applied and Preventive Psychology* 4(3):143–166, 1995.

Pope, H.G., and Hudson, J.I. Is childhood sexual abuse a risk factor for bulimia nervosa? *American Journal of Psychiatry* 149(4):455–463, 1992.

Potter-Efron, R.T., and Potter-Efron, P.S. *Anger, Alcoholism, and Addiction: Treating Individuals, Couples and Families.* New York: W.W. Norton, 1991.

Pribor, E.F., and Dinwiddie, S.H. Psychiatric correlates of incest in childhood. *American Journal of Psychiatry* 149:52–56, 1992.

Price, R.K.; Breslau, N.; Chilcoat, H.D.; Triffleman, E.; True, W.R.; and Kosten, T.R. Symposium XIV: PTSD and substance abuse: Epidemiology, genetics and neurobiology. In: Leshner, A.I., ed. *Problems of Drug Dependence 1997: Proceedings from the 59th Annual Scientific Meeting of the College on Problems of Drug Dependence.* NIDA Research Monograph Series, Number 178. NIH Pub. No. 98-4305. Rockville, MD: National Institute on Drug Abuse, 1998. pp. 48–51.

Putnam, F.W. *Dissociation in Children and Adolescents: A Developmental Perspective.* New York: Guilford Press, 1997.

Rabasca, L. APA pursues "test cases" to set legal precedents. *APA Monitor* 29(11), 1998. http://www.apa.org/monitor/nov98/mc.html [Accessed Jan. 27, 1999].

Rausch, K., and Knutson, J.F. The self-report of personal punitive childhood experiences and those of siblings. *Child Abuse and Neglect* 15(1–2):29–36, 1991.

Rauch, S.L.; van der Kolk, B.A.; Fisler, R.E.; Alpert, N.M.; Orr, S.P.; Savage, C.R.; Fischman, A.J.; Jenike, M.A.; and Pitman, R.K. A symptom provocation study of posttraumatic stress disorder using positron emission tomography and script-driven imagery. *Archives of General Psychiatry* 53(5):380–387, 1996.

Ray, O., and Ksir, C. *Drugs, Society, and Human Behavior.* St. Louis, MO: Mosby, 1996.

Reed, B.G. Linkages: Battering, sexual assault, incest, child sexual abuse, teen pregnancy, dropping out of school, and the drug and alcohol connection. In: Roth, P., ed. *Alcohol and Drugs Are Women's Issues.* Vol. 1. *A Review of Issues.* Metuchen, NJ: Scarecrow Press, 1991. pp. 130–149.

Reed, R.J.; Grant, I.; and Rourke, S.B. Long-term abstinent alcoholics have normal memory. *Alcoholism, Clinical and Experimental Research* 16(4):677–683, 1992.

Reid, J.; Macchetto, P.; and Foster, S. *No Safe Haven: Children of Substance-Abusing Parents.* New York: National Center on Addiction and Substance Abuse at Columbia University, 1999.

Resnick, H.S. Psychometric review of national women's study (NWS) event history-PTSD Module. In: Stamm, B.H., ed. *Measurement of Stress, Trauma, and Adaptation.* Lutherville, MD: Sidran Press, 1996a. pp. 214–217.

Resnick, H.S. Psychometric review of trauma assessment for adults (TAA). In: Stamm, B.H., ed. *Measurement of Stress, Trauma, and Adaptation.* Lutherville, MD: Sidran Press, 1996b. pp. 362–365.

Resnick, H.S.; Falsetti, S.A.; Kilpatrick, D.G.; and Freedy, J.R. Assessment of rape and other civilian trauma-related post-traumatic stress disorder: Emphasis on assessment of potentially traumatic events. In: Miller, T.W., ed. *Stressful Life Events.* Madison, WI: International Universities Press, 1996. pp. 231–266.

Ripple, L. *Motivation, Capacity and Opportunity: Studies in Casework Theory and Practice.* Chicago: University of Chicago Press, 1964.

Robins, L.; Helzer, J.E.; Croughan, J; and Ratcliff, K.S. National Institute of Mental Health Diagnostic Interview Schedule: Its history, characteristics, and validity. *Archives of General Psychiatry* 38(4):381–389, 1981.

Rodning, C.; Beckwith, L.; and Howard, J. Prenatal exposure to drugs: Behavioral distortions reflecting CNS impairment? *Neurotoxicology* 10(3):629–634, 1989.

Roesler, T.A., and Dafler, C.E. Chemical dissociation in adults sexually victimized as children: Alcohol and drug use in adult survivors. *Journal of Substance Abuse Treatment* 10(6):537–543, 1993.

Rogers, C.R. A theory of therapy, personality, and interpersonal relationships as developed in the client-centered framework. In: Koch, S., ed. *Psychology: The Study of a Science.* Vol. 3. *Formulations of the Person and the Social Context.* New York: McGraw-Hill, 1959. pp. 184–256.

Rohner, R.P. *Handbook for the Study of Parental Acceptance and Rejection,* rev. ed. Storrs, CT: Center for the Study of Parental Acceptance and Rejection, University of Connecticut, 1990.

Rohsenow, D.J., Corbett, R.; and Devine, D. Molested as children: A hidden contribution to substance abuse? *Journal of Substance Abuse Treatment* 5:13–18, 1988.

Rose, S.M. Acknowledging abuse backgrounds of intensive case management clients. *Community Mental Health Journal* 27(4):255–263, 1991.

Ross, C.A.; Anderson, G.; Heber, S.; and Norton, G.R. Dissociation and abuse among multiple personality clients, prostitutes, and exotic dancers. *Hospital and Community Psychiatry* 41(3):328–330, 1990.

Rounsaville, B.J.; Glazer, W.; Wilber, C.H.; Weissman, M.M.; and Kleber, H.D. Short-term interpersonal psychotherapy in methadone-maintained opiate addicts. *Archives of General Psychiatry* 40(6):629–636, 1983.

Rowan, A.B., and Foy, D.W. PTSD in child sexual abuse. *Journal of Traumatic Stress* 6: 3–20, 1993.

Rowan, A.B.; Foy, D.W.; Rodriguez, N.; and Ryan, S. Posttraumatic stress disorder in a clinical sample of adults sexually abused as children. *Child Abuse and Neglect* 18(1):51–61, 1994.

Rubin, J. Practical suggestions for working with substance abusing families. *The Source* 8(2):16–17, 1998.

Russell, D.E. The incidence and prevalence of intrafamilial and extrafamilial sexual abuse of female children. *Child Abuse and Neglect* 7:133–146, 1983.

Ryan, V., and Popour, J. *Five Year Women's Plan.* Capital Area Substance Abuse Commission for the Office of Substance Abuse, Michigan Department of Health. Lansing, MI: Michigan Department of Health, 1983.

Saakvitne, K.W., and Gamble, S. *Risking Connection: Responding Helpfully to the Needs of Trauma Survivors.* Lutherville, MD: Sidran Press, in press.

Satir, V. *Peoplemaking.* Palo Alto, CA: Science and Behavior Books, 1972.

Satir, V., and Baldwin, M. *Satir Step by Step: A Guide to Creating Change in Families.* Palo Alto, CA: Science and Behavior Books, 1983.

Schene, P.A. Past, present, and future roles of child protective services. *Future of Children* 8(1):23–38, 1998.

Sedlak, A.J., and Broadhurst, D.D. *The Third National Incidence Study of Child Abuse and Neglect.* National Center on Child Abuse and Neglect. Washington, DC: U.S. Government Printing Office, 1996.

Shaver, P.R.; Goodman, G.S.; Rosenberg, M.S.; and Orcutt, H. The search for a definition of psychological maltreatment. *Development and Psychopathology* 3:79–86, 1991.

Sheehan, D.V.; Lecrubier, Y.; Janavs, J.; Knapp, E.; Weiller, E.; Amorim, P.; Lepine, J.P.; Sheehan, M.F.; Baker, R.R.; and Sheehan, K.H. *Mini International Neuropsychiatric Interview.* Tampa, FL: University of South Florida Institute for Research in Psychiatry, 1994.

Sheehan, D.V.; Lecrubier, Y.; Sheehan, K.H.; Janavs, J.; Weiller, E.; Keskiner, A.; Schinka, J.; Knapp, E.; Sheehan, M.F.; and Dunbar, G.C. "Reliability and validity of the Mini International Neuropsychiatric Interview (MINI): According to the SCID-P." Unpublished manuscript, 1996.

Sheehan, P.L. Treating intimacy issues of traumatized people. In: Williams, M.B., and Sommer, J.F., Jr., eds. *Handbook of Post-Traumatic Therapy.* Westport, CT: Greenwood Press, 1994. pp. 94–105.

Sheridan, M.J. A proposed intergenerational model of substance abuse, family functioning, and abuse/neglect. *Child Abuse and Neglect* 19(5): 519–530, 1995.

Silverman, A.B.; Reinherz, H.Z.; and Giaconia, R.M. The long-term sequelae of child and adolescent abuse: A longitudinal community study. *Child Abuse and Neglect* 20(8):709–723, 1996.

Simpson, T.L. The clinical problems and outcomes of people with substance use disorders who experienced childhood abuse: A review, in press.

Simpson, T.L., and Miller, W.R. The relationship between childhood abuse and substance abuse: A review. Manuscript in preparation.

Simpson, T.L.; Westerberg, V.; Little, L.M.; and Trujillo, M. Screening for childhood physical and sexual abuse among outpatient substance abusers. *Journal of Substance Abuse Treatment* 11(4):347–358, 1994.

Singer, M.I.; Petchers, M.K.; and Hussey, D. The relationship between sexual abuse and substance abuse among psychiatrically hospitalized adolescents. *Child Abuse and Neglect* 13(3):319–325, 1989.

Spitzer, R.L., and Endicott, J. *Schedule for Affective Disorders and Schizophrenia SADS,* 3rd ed. New York: New York State Psychiatric Institute, 1978.

Springer, C. Female adolescents, the experience of violence, and the meaning of the body. *Clinical Social Work Journal* 25:281–296, 1997.

Stamm, B.H. *Secondary Traumatic Stress: Self-Care Issues for Clinicians, Researchers, and Educators,* 2nd ed. Lutherville, MD: Sidran Press, 1999.

Steele, B. Reflections on the therapy of those who maltreat children. In: Helfer, R.E., and Kempe, R.S., eds. *The Battered Child,* 4th ed. Chicago: University of Chicago Press, 1987.

Stein, M.B.; Koveroa, C.; Hanna, C.; Torchia, M.G.; and McClarty, B. Hippocampal volume in women victimized by childhood sexual abuse. *Psychological Medicine* 27(4):951–959, 1997.

Steinberg, K.L.; Levine, M.; and Doueck, H.J. Effects of legally mandated child-abuse reports on the therapeutic relationship: A survey of psychotherapists. *American Journal of Orthopsychiatry* 67(1):112–122, 1997.

Steinglass, P. *The Alcoholic Family.* New York: BasicBooks, 1987.

Stephenson, M.D. "Evaluating the Impact of Incest on the Recovery of Alcohol/Drug Dependent Women in Residential Care." Ph.D. dissertation, University of Nebraska, 1990. Abstract in *Dissertation Abstracts International* 51(3):1514–B, 1990.

Stewart, S.H. Alcohol abuse in individuals exposed to trauma: A critical review. *Psychological Bulletin* 120(1):83–112, 1996.

Straton, D. Catharsis reconsidered. *Australian and New Zealand Journal of Psychiatry* 24:543–551, 1990.

Straus, M.A., and Gelles, R.J. How violent are American families? Estimates from the National Family Violence Survey and other studies. In: Straus, M.A., and Gelles, R.J., eds. *Physical Violence in American Families: Risk Factors and Adaptations to Violence in 8,145 Families.* New Brunswick, NJ: Transaction Publishers, 1990.

Straus, M.A., and Kantor, G.K. Corporal punishment of adolescents by parents: A risk factor in the epidemiology of depression, suicide, alcohol abuse, child abuse, and wife beating. *Adolescence* 29:543–561, 1994.

Substance Abuse and Mental Health Services Administration. *Preliminary Estimates From the 1995 National Household Survey on Drug Abuse.* Advance Report No. 18, August 1996. http://www.samhsa.gov/oas/nhsda/ar18ttoc.htm [Accessed Dec. 12, 1998].

Sue, D.W.; Arredondo, P.; and McDavis, R.J. Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling and Development* 70(4):477–486, 1992.

Sullivan, R.A.; Schaefer, J.L.; and Goldstein, F.L. Child molestation. *American Family Physician* 19(3):127–132, 1979.

Surrey, J. The "self-in-relation": A theory of women's development. *Work in Progress* No. 13:1–10, 1985.

Swan, N. Exploring the role of child abuse in later drug use. *NIDA Notes* 13(2):1–4, 1998. http://www.nida.nih.gov/NIDA_Notes/NNVol13N2/exploring.html [Accessed Nov. 16, 1998].

Swift, W.; Copeland, J.; and Hall, W. Characteristics of women with alcohol and other drug problems: Findings of an Australian national survey. *Addiction* 91(8):1141–1150, 1996.

Thompson, V.L. Perceived experiences of racism as stressful life events. *Community Mental Health Journal* 32:223–233, 1996.

Traux, C.B., and Carkhoff, R.R. *Toward Effective Counseling and Psychotherapy: Training and Practice.* Chicago: Aldine Publishing, 1967.

Trickett, P.K., and McBride-Chang, C. The developmental impact of different forms of child abuse and neglect. *Developmental Review* 15(3):311–337, 1995.

Trickett, P.K., and Putnam, F.W. Impact of child sexual abuse on females: Toward a developmental, psychobiological integration. *Psychological Science* 4:81–87, 1993.

Tunving, K., and Nilsson, K. Young female drug addicts in treatment: A 12 year perspective. *Journal of Drug Issues* 15(3):367–382, 1985.

Turkus, J.A., and Cohen, B.M. *The Spectrum of Dissociative Disorders: An Overview of Diagnosis and Treatment.* http:www.voiceofwomen.com/centerarticle.html [Accessed Oct. 14, 1998].

Tyler, R.; Howard, J.; Espinosa, M.; and Doakes, S.S. Placement with substance-abusing mothers vs. placement with other relatives: Infant outcomes. *Child Abuse and Neglect* 21(4):337–349, 1997.

U.S. Department of Health and Human Services. *Blending Perspectives and Building Common Ground: A Report to Congress on Substance Abuse and Child Protection.* Washington, DC: U.S. Government Printing Office, 1999. http://aspe.os.dhhs.gov/hsp/subabuse99.htm [Accessed May 13, 1999].

U.S. Department of Justice. Federal Bureau of Prisons. *Triad Drug Treatment Evaluation—Six-Month Report: Executive Summary* (1998). http://www.bop.gov [Accessed Jan. 15, 1999].

Valentine, P.V. Traumatic incident reduction: A review of a new intervention. *Journal of Family Psychotherapy* 6(2):73–78, 1995.

Valentine, P.V. Traumatic incident reduction: Treatment of trauma-related symptoms in incarcerated females. *Proceedings of the Tenth National Symposium on Doctoral Research in Social Work.* Columbus, OH: Ohio State University College of Social Work, 1998.

Valentine, P.V. Traumatic Incident Reduction (TIR): Brief, intense treatment for battered women. *Crisis Intervention and Time-Limited Treatment* 5(2): in press.

Valentine, P.V., and Smith, T.E. A qualitative study of client perceptions of Traumatic Incident Reduction (TIR): A brief trauma treatment. *Crisis Intervention and Time-Limited Treatment* 4(1): 1–12, 1998.

Valentine, P.V., and Smith, T.E. Evaluating Traumatic Incident Reduction (TIR) Therapy with female inmates: A randomized controlled clinical trial. *Research on Social Work Practice,* in press.

Van Dam, C.; Halliday, L.; and Bates, C. The occurrence of sexual abuse in a small community. *Canadian Journal of Community Mental Health* 4(1):105–111, 1985.

van der Kolk, B.A. The psychobiology of the trauma response: Hyperarousal, constriction, and addiction to traumatic reexposure. In: van der Kolk, B.A., ed. *Psychological Trauma.* Washington, DC: American Psychiatric Press, 1987. pp. 63–87.

van der Kolk, B.A. The body keeps the score: Approaches to the psychobiology of posttraumatic stress disorder. In: van der Kolk, B.A.; McFarlane, A.C.; and Weisaeth, L., eds. *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body, and Society.* New York: Guilford Press, 1996. pp. 214–241.

VanHasselt, V.B.; Ammerman, R.T.; Glancy, L.J.; and Bukstein, O.G. Maltreatment in psychiatrically hospitalized dually diagnosed adolescent substance abusers. *Journal of the American Academy of Child and Adolescent Psychiatry* 31:868–874, 1992.

Wald, M.S. Defining psychological maltreatment: The relationship between questions and answers. *Development and Psychopathology* 3:111–118, 1991.

Wald, R.; Harvey, S.M.; and Hibbard, J. A treatment model for women substance users. *International Journal of the Addictions* 30(7):881–888, 1995.

Walker, C.; Zangrillo, P.; and Smith J. *Parental Drug Abuse and African American Children in Foster Care: Issues and Study Findings.* Washington, DC: National Black Child Development Institute, 1991.

Wallen, J., and Berman, K. Possible indicators of childhood sexual abuse for individuals in substance abuse treatment. *Journal of Child Sexual Abuse* 1(3):63–74, 1992.

Wand, G.S.; Mangold, D.; El Deiry, S.; McCaul, M.E.; and Hoover, D. Family history of alcoholism and hypothalamic opioidergic activity. *Archives of General Psychiatry* 55(12):1114–1119, 1998.

Wang, C.T., and Daro, D. *Current Trends in Child Abuse Reporting and Fatalities: The Results of the 1997 Annual Fifty State Survey.* Chicago: National Committee to Prevent Child Abuse, 1998.

Washton, A.M. Structured outpatient group therapy. In: Lowinson, J.H.; Ruiz, P.; Millman, R.B.; and Langrod, J.G., eds. *Substance Abuse: A Comprehensive Textbook,* 3rd ed. Baltimore: Williams & Wilkins, 1997. p. 440.

Watson, H., and Levine, M. Psychotherapy and mandated reporting of child abuse. *American Journal of Orthopsychiatry* 59:246–256, 1989.

Weathers, F.W., and Litz, B.T. Psychometric properties of the clinician-administered PTSD scales. *PTSD Research Quarterly* 5:2–6, 1994.

Wedenoja, M., and Reed, B. Women's groups as a form of intervention for drug dependent women. In: Beschner, G.M.; Reed, B.G.; and Mondanaro, J., eds. *Treatment Services for Drug Dependent Women.* Vol. II. NIDA Treatment Research Monograph Series. DHHS Pub. No. (ADM) 82-1219. Rockville, MD: National Institute on Drug Abuse, 1982. pp. 62–136.

Wegsheider, S. *Another Chance: Hope and Health for the Alcoholic Family.* Palo Alto, CA: Science and Behavior Books, 1981.

Wessells, D.T., Jr., ed. *Professional Burnout in Medicine and the Helping Professions.* New York: Haworth Press, 1989.

Whipple, E.E., and Richey, C.A. Crossing the line from physical discipline to child abuse: How much is too much? *Child Abuse and Neglect* 21:431–444, 1997.

Whitfield, C.L. Children of alcoholics: Treatment issues. In: Foster, W.D.; DeLuca, J.R.; and O'Gorman, P.A., eds. *Services for Children of Alcoholics.* NIAAA Research Monograph Series, Number 4. DHHS Pub. No. (ADM) 81-1007. Silver Spring, MD: National Institute on Alcohol Abuse and Alcoholism, 1981. pp. 66–80.

Whitfield, C.L. Stress management and spirituality during recovery: A transpersonal approach. *Alcoholism Treatment Quarterly* 1(1):3–54, 1984.

Whitfield, C.L. *Healing the Child Within: Discovery and Recovery for Adult Children of Dysfunctional Families.* Pompano Beach, FL: Health Communications, 1987.

Whitfield, C.L. *A Gift to Myself: A Personal Guide to Healing My Child Within.* Deerfield Beach, FL: Health Communications, 1990.

Whitfield, C.L. *Boundaries and Relationships: Knowing, Protecting, and Enjoying the Self.* Deerfield Beach, FL: Health Communications, 1993.

Whitfield, C.L. *Memory and Abuse: Remembering and Healing the Effects of Trauma.* Deerfield Beach, FL: Health Communications, 1995.

Whitfield, C.L. Internal corroboration of child sexual abuse. *Journal of Child Sexual Abuse* 6(3):99–122, 1997a.

Whitfield, C.L. Traumatic amnesia: The evolution of our clinical and legal understanding. *Sexual Addiction and Compulsivity* 4(2):107–135, 1997b.

Whitfield, C.L. Internal evidence and corroboration of traumatic memories of child sexual abuse and addictive disorders. *Sexual Addiction and Compulsivity* 5:269–292, 1998.

Widom, C.S.; Ireland, T.; and Glynn, P.J. Alcohol abuse in abused and neglected children followed-up: Are they at increased risk? *Journal of Studies on Alcohol* 56:207–217, 1995.

Williams, L.M. Recall of childhood trauma: A prospective study of women's memories of child sexual abuse. *Journal of Consulting and Clinical Psychology* 62:1167–1176, 1994.

Wilson, J.P., and Lindy, J.D., eds. *Countertransference in the Treatment of PTSD.* New York: Guilford Press, 1994.

Windle, M.; Windle, R.C.; Scheidt, D.M.; and Miller, G.B. Physical and sexual abuse and associated mental disorders among alcoholic inpatients. *American Journal of Psychiatry* 152(9):1322–1328, 1995.

Wolfe, D.A.; Sas, L.; and Wekerle, C. Factors associated with the development of posttraumatic stress disorder among child victims of sexual abuse. *Child Abuse and Neglect* 18:37–50, 1994.

Wolfner, G.D., and Gelles, R.J. A profile of violence toward children: A national study. *Child Abuse and Neglect* 17:197–212, 1993.

Wolin, S., and Wolin, S. Resilience among youth growing up in substance-abusing families. *Pediatric Clinics of North America* 42(2):415–429, 1995.

Wyatt, G.E. The sexual abuse of Afro-American and White American women in childhood. *Child Abuse and Neglect* 9:507–519, 1985.

Wyatt, G.E., and Peters, S.D. Issues in the definition of child sexual abuse in prevalence research. *Child Abuse and Neglect* 10:231–240, 1986a.

Wyatt, G.E., and Peters, S.D. Methodological considerations in research on the prevalence of child sexual abuse. *Child Abuse and Neglect* 10:241–251, 1986b.

Young, E.B. The role of incest issues in relapse and recovery. In: Washton, A.M., ed. *Psychotherapy and Substance Abuse: A Practitioner's Handbook.* New York: Guilford Press, 1995. pp. 451–469.

Young, N.K.; Gardner, S.L.; and Dennis, K. *Responding to Alcohol and Other Drug Problems in Child Welfare: Weaving Together Practice and Policy.* Washington, DC: Child Welfare League of America, 1998.

Zierler, S.; Feingold, L.; Laufer, D.; Velentgas, P.; Kantrowitz-Gordon, I.; and Mayer, K. Adult survivors of childhood sexual abuse and subsequent risk of HIV infection. *American Journal of Public Health* 81(5):572–575, 1991.

Appendix B
Protecting Clients' Privacy

by Margaret K. Brooks, Esq.

The Federal Confidentiality Law and Regulations

Among Americans, there is a widespread perception that people with substance abuse disorders are weak or morally impaired. The Federal confidentiality law and regulations grew out of a concern that this social stigma and discrimination against recovering substance users might deter people from entering treatment. The law is codified as 42 U.S.C. §290dd-2. The implementing Federal regulations, "Confidentiality of Alcohol and Drug Abuse Patient Records," are contained in 42 Code of Federal Regulations (C.F.R.), Part 2.

The Federal law and regulations severely restrict communications about identifiable individuals by "programs" that provide substance use diagnosis, treatment, or referral for treatment (§2.11) (citations in the form "§2..." refer to specific sections of 42 C.F.R. Part 2). The purpose of the law and regulations is to decrease the risk that information about individuals in recovery will be disseminated and that they will be subjected to discrimination and to encourage people to seek treatment for substance abuse disorders.

The regulations restrict communications more tightly in many instances than, for example, the laws governing either doctor–patient or attorney–client privilege. Violating the regulations is punishable by a fine of up to $500 for a first offense and up to $5,000 for each subsequent offense (§2.4). Some may view these Federal regulations governing communication about the client and protecting privacy rights as an irritation or a barrier to achieving program goals. However, most of the problems that may crop up under the regulations can be easily avoided through planning ahead. Familiarity with the regulations' requirements will assist communication. It also can reduce confidentiality-related conflicts among the program, client, and outside agencies so that these conflicts rarely occur.

What Types of Programs Are Governed by the Regulations?

Any program that specializes, in whole or in part, in providing treatment, counseling, and/or assessment and referral services for clients with substance abuse disorders must comply with the Federal confidentiality regulations (§2.12(e)). Although the Federal regulations apply only to programs that receive Federal assistance, this assistance includes indirect forms of Federal aid such as tax-exempt status or State or local government funding (in whole or in part) from the Federal government.

Coverage under the Federal regulations is not contingent upon how a program labels its services. A "prevention" program is not excused from adhering to the confidentiality rules. The kind of services, not the label, determines whether the program must comply with the Federal law.

Overview of Federal Confidentiality Laws

The Federal confidentiality laws and regulations protect any information about a client who has applied for or received any substance abuse-related assessment, treatment, or referral services from a program covered under the law. Services applied for or received can include assessment, diagnosis, individual counseling, group counseling, treatment, or referral for treatment. The restrictions on disclosure (the act of making information known to another) apply to any information that would identify the client as a substance user either directly or by implication. The general rule applies from the time the client makes an appointment, applies for services, is assessed, or begins treatment. It also applies to former clients. Furthermore, the rule applies whether or not the person making an inquiry already has the information, has other ways of getting it, has some form of official status, is authorized by State law, or comes armed with a subpoena or search warrant.

When May Confidential Information Be Shared With Others?

Information protected by the Federal confidentiality regulations may always be disclosed after the client signs a proper consent form. (For minors, however, parental consent must also be obtained in some States.) The regulations also permit disclosure without the client's consent in several situations, including during medical emergencies, in communications among program staff, when reporting is mandated as in instances of child abuse or neglect, or when there is a danger to self or others. Nevertheless, obtaining the client's consent is the most common exception to the general rule prohibiting disclosure. The regulations' requirements regarding consent are strict and somewhat unusual and must be carefully followed.

Rules for Obtaining Client Consent To Disclose Treatment Information

Most disclosures are permissible if a client has signed a valid consent form that has not expired or been revoked (§2.31). However, no information obtained from a provider—even with the client's consent—may be used in a criminal investigation or prosecution of a client unless a court order also has been issued in accordance with §2.65 (see §2.12(a) and (d)).

A proper consent form must be in writing and must contain *each* of the items specified in §2.31, as follows:

- The name or general description of the program(s) making the disclosure
- The name or title of the individual or organization that will receive the disclosure
- The name of the client who is the subject of the disclosure
- The purpose or need for the disclosure
- How much and what kind of information will be disclosed
- A statement that the client may revoke (take back) the consent at any time, except to the extent that the program has already acted on it
- The date, event, or condition upon which the consent will expire if not previously revoked

- The signature of the client (and, in some States, that of her parent)
- The date on which the consent is signed

A general medical release form, or any consent form that does not contain all of the elements listed above, is not acceptable. (See sample consent form in Figure B-1.) Several items on this list deserve further explanation and are discussed below: the purpose of the disclosure and how much and what kind of information will be disclosed, the client's right to revoke consent, expiration of the consent form, and the required notice against rereleasing information. A note about agency use of the consent forms follows.

The Purpose of the Disclosure And the Information That Will Be Disclosed

These two items are closely related. All disclosures, and especially those made pursuant to a consent form, must be limited to information that is necessary to accomplish the need or purpose for the disclosure (§2.13(a)). It would be improper to disclose everything in a client's file if the recipient of the information needs only one specific piece of information.

The purpose or need for the communication of information must be specified on the consent form. Once the purpose or need has been identified, it is easier to determine how much and what kind of information will be disclosed and to tailor it to what is essential to the specified need or purpose. Thus, the amount and type of information required must be written into the consent form. (The release of any HIV-related information may require a separate consent form, depending on the requirements of State law. For a discussion of the confidentiality of HIV-related information, see the forthcoming TIP, *Substance Abuse Treatment for Persons With HIV/AIDS*, in press [b].)

As an illustration, if a client must have participation in treatment verified to continue receiving public assistance, the purpose of the disclosure would be to "verify treatment status to the welfare authorities," and the amount and kind of information to be disclosed would be "time and dates of appointments" or "attendance." The disclosure would then be limited to a statement that "Jane Doe (the client) is receiving counseling at the XYZ Drug Treatment Program on Tuesday afternoons at 2 p.m."

The Client's Right To Revoke Consent

The client may revoke consent at any time, and the consent form must include a statement to this effect. Revocation need not be in writing. If a program has already made a disclosure prior to the revocation, acting in reliance on the client's signed consent, it is not required to retrieve the information it has already disclosed.

The regulations also provide that "acting in reliance" includes provision of services while relying on a consent form permitting disclosures to a third-party payor. (Third-party payors are health insurance companies, Medicaid, or any party that pays the bills other than the client's family.) Thus, a program can bill the third-party payor for services provided before the consent was revoked. However, a program that continues to provide services after a client has revoked a consent authorizing disclosure to a third-party payor does so at its own financial risk.

Expiration of Consent Form

The consent form must contain a date, event, or condition on which it will expire if not previously revoked. A consent must last "no longer than reasonably necessary to serve the purpose for which it is given" (§2.31(a)(9)). Depending on the purpose of the consented

Figure B-1
Sample Consent Form

Consent for the Release of Confidential Information

I, ______________________________, authorize XYZ Clinic to receive

(name of client or participant)

from/disclose to ______________________________

____

(name of person and organization)

for the purpose of ______________________________

____

(need for disclosure)

the following information ______________________________

____

(nature of the disclosure)

____

I understand that my records are protected under the Federal and State Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event this consent expires automatically on

______________ unless otherwise specified below.

(date, condition, or event)

Other expiration specifications:

____

____

Date executed

____

Signature of client

____

Signature of parent or guardian, where required disclosure, the consent form may expire in 5 days, 6 months, or longer. Sound practice calls for adjusting the expiration date in this way, rather than imposing a set time period, say 60 to 90 days. For example, providers sometimes find themselves in a situation requiring disclosure when the client's consent form has expired. This means at the least that the client must return to the agency to sign a new consent form. At worst, the client has left or is unavailable, and the agency will not be able to make the disclosure.

The consent form need not contain a specific expiration date but may instead specify an event or condition. For example, if a client is in treatment as part of a service plan drawn up by the child protective services (CPS) agency, the consent form can be drafted to expire at the completion of the case with the CPS agency. Or if a client is being referred to a specialist for a single appointment, the consent form should stipulate that consent will expire after this appointment.

Required Notice Against Redisclosing Information

Once the consent form is properly completed, one formal requirement remains. Any disclosure made with the client's consent must be accompanied by a written statement that the information disclosed is protected by Federal law and that the recipient cannot further disclose or release such information unless permitted by the regulations (§2.32). This statement, not the consent form itself, should be delivered and explained to the recipient of the information at the time of disclosure or earlier. (Of course, a client may sign a consent form authorizing redisclosure.)

Note on Agency Use of Consent Forms

The fact that a client has signed a proper consent form authorizing release of information does not compel a program to make the proposed disclosure, unless the program has also received a subpoena or court order (§§2.3(b)(1), 2.61(a)(b)). In most cases, the decision whether to make a disclosure authorized by a client's signed consent is up to the program, unless State law requires or prohibits a particular disclosure even if consent is given. The program's only obligation under the Federal regulations is to refuse to honor a consent that is expired, deficient, or otherwise known to be revoked, false, or incorrect (§2.31(c)).

In general, it is best to follow this rule: disclose only what is necessary and only as long as necessary, keeping in mind the purpose of disclosing the information.

Rules for Communicating With CPS Agencies and Others About Clients

Communicating With CPS Agencies, Coordinating Care, and Making Referrals

Programs treating parents involved with CPS agencies may be called on to provide information to CPS or to confer on an ongoing basis with other agencies, such as mental health or child welfare programs. The best way to proceed is to obtain the client's consent. Care should be taken in wording the consent form to permit the kinds of communications necessary.

For example, if the program is treating a client who has been referred to treatment and whose parental rights are at risk, the purpose of disclosure might be to "assist the client to comply with the CPS system's requirements, goals, and timetables," or to "supply periodic reports about attendance," and "how much and what kind of information will be disclosed" might be "attendance" or "progress in treatment."

On the other hand, if the program needs ongoing communications with a mental health provider, the purpose of the disclosure would be "coordination of care for John Doe," and "how much and what kind of information will be disclosed" might be "treatment status, treatment issues, and progress in treatment."

Note that the kinds of information disclosed in these two examples are quite different. The program might well share detailed clinical information about a client with a mental health provider if sharing would assist in coordinating care. Disclosure to CPS agencies should be limited to a brief statement about the client's attendance or progress in treatment. Disclosure of detailed clinical information to CPS agencies could, in many circumstances, be inappropriate.

The program should also give considerable thought to the date or event that will end the period of consent. For coordinating care with a mental health program, it might be appropriate to have the consent form expire when treatment by either agency ends. A consent form permitting disclosures to CPS agencies might expire when the client's CPS case is closed.

Making Referrals

Programs treating clients often refer them to other health care or social service agencies. Giving a client the name and telephone number of an outside gynecologist, tutoring service, or training program might not be effective unless the client's treatment counselor calls to set up the appointment for the client. However, such a call is a disclosure of confidential information that the client has a substance abuse problem, and thus the counselor is required to obtain the client's consent in writing (as well as parental consent in States requiring it).

Special Consent Rules for Clients Involved in the Justice System

Programs assessing or treating clients who are involved in the criminal justice system (CJS) must still follow the Federal confidentiality rules. However, special rules apply when a client comes for assessment or treatment as an official condition of probation, sentence, dismissal of charges, release from detention, or other disposition of a criminal justice proceeding. (Note that these rules do *not* apply to clients referred by the CPS system or "mandated" into treatment by CPS. They apply only to clients mandated into treatment as a condition of the disposition of a criminal case.)

A consent form (or court order) is required before a program can disclose information about a client who is the subject of CJS referral. However, the rules are different concerning the length of time a consent is valid and the process for revoking it (§2.35). Specifically, the regulations require that the following factors be considered in determining how long a criminal justice consent will remain in effect:

- Anticipated duration of treatment
- Type of criminal proceeding
- Need for treatment information in dealing with the proceeding
- Time of the final disposition
- Anything else the client, program, or justice agency believes is relevant

These rules allow programs to draft the consent form to expire "when there is a substantial change in the client's justice system status." A substantial change in justice system status occurs whenever the client moves from one phase of the CJS to the next. For example, for a client on probation, a change in CJS status would occur when the probation ends, either by successful completion or revocation. Thus, the program could provide an assessment and periodic reports to the client's probation officer and could even testify at a probation revocation hearing if it so desired, because no change in status would occur until after that hearing.

An important difference between the regular consent form and the CJS consent form is that the Federal regulations permit the program to draft the CJS consent form so that it cannot be revoked until a specified date or condition occurs. The regulations permit the CJS consent form to be irrevocable so that a client who has agreed to enter treatment in lieu of prosecution or punishment cannot then prevent the court, probation department, or other agency from monitoring her progress. Note that although a CJS consent may be made irrevocable for a specified period of time, that period must end no later than the time of the final disposition of the juvenile or criminal justice proceeding. Thereafter, the client may freely revoke consent. A sample CJS consent form appears in Figure B-2.

Other Exceptions to the General Rule

Chapter 6 made reference to other exceptions to the general rule prohibiting disclosure of information about a client who seeks or receives substance use treatment services. These include

- Disclosures that do not reveal "client-identifying" information
- Disclosures authorized by court order
- Disclosures to an outside agency that provides a service to the program
- Mandated reporting of child abuse or neglect
- Imminent danger to self or others

Disclosures That Do Not Reveal "Client-Identifying" Information

Federal regulations permit treatment programs to disclose information about a client if the program reveals no client-identifying information. "Client-identifying" information is information that identifies an individual as a substance user. Thus, a program may disclose information about a client if that information does not identify him as a substance user or support anyone else's identification of the client as a substance user. For example, a counselor in a program that provides services to clients with other problems or illnesses as well as substance abuse disorders may disclose information about an identified client to a peer in another treatment program or to a lawyer at a legal services program (to obtain advice, for example) as long as the counselor does not reveal the fact that the client has a substance abuse disorder or is receiving treatment (§2.12(a)(i)). Similarly, a counselor employed by a program that is part of a general hospital could make such a disclosure, if no mention is made of the client's substance abuse or participation in a treatment program. Of course, if information the counselor must discuss with the colleague or lawyer involves substance abuse, this exception will not work.

Programs that provide only substance abuse services cannot disclose information that identifies a client under this exception, because telling a colleague or a lawyer that the call is being made from the "XYZ Drug Treatment Program" automatically identifies the client as a participant in the program. However, a free-standing program can sometimes make "anonymous" disclosures; that is, disclosures that do not mention the name of the program or otherwise reveal the client's status as a substance user. In other words, a counselor could call a colleague or a lawyer and ask for advice, yet not be obliged to identify the program by name.

Court-Ordered Disclosures

A State or Federal court may issue an order permitting a program to make a disclosure about a client that would otherwise be forbidden. However, a court may issue one of these authorizing orders only after it follows special procedures and makes particular determinations required by the regulations. *A subpoena, search warrant, or arrest warrant, even when signed by a judge, is not sufficient, standing alone, to require or even to permit a program to disclose information* (§2.61). Additional

Figure B-2
Consent Form: Criminal Justice System Referral

Consent for the Release of Confidential Information

I, ____, hereby consent to communication
(name of defendant)

between ____ and
(treatment program)

____
(court, probation, parole, and/or other referring agency)

the following information____
(nature of the information, as limited as possible)

The purpose of and need for the disclosure is to inform the criminal justice agency(ies) listed above of my attendance and progress in treatment. The extent of information to be disclosed is my diagnosis, information about my attendance or lack of attendance at treatment sessions, my cooperation with the treatment program prognosis, and

____

____

I understand that this consent will remain in effect and cannot be revoked by me until:

_____ There has been a formal and effective termination or revocation of my release from confinement, probation, or parole, or other proceeding under which I was mandated into treatment or

_____ ____
(other time when consent can be revoked and/or expires)

I also understand that any disclosure made is bound by Part 2 of Title 42 of the Code of Federal Regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records and that recipients of this information may redisclose it only in connection with their official duties.

________________ ______________________________
(Date) (Signature of defendant/patient)

____
(Signature of parent, guardian, or
authorized representative if required)

information about dealing with subpoenas appears in *Confidentiality: A Guide to the Federal Laws and Regulations* (Legal Action Center, 1995). Before a court can issue an order authorizing a disclosure about a client that is otherwise forbidden, the program and the client whose records are sought must be given notice of the application for the order, as well as an opportunity to make an oral or written statement to the court. (If the information is being sought to investigate or prosecute a client for a crime, however, only the program need be notified (§2.65). If the information is sought to investigate or prosecute the program, no prior notice at all is required (§2.66).)

Generally, the application and any court order must use a fictitious (made-up) name for any known client, *not* the real name. All court proceedings in connection with the application must remain confidential unless the client requests otherwise (§§2.64(a), (b), 2.65, 2.66).

Before issuing an authorizing order, the court must find that there is "good cause" for the disclosure. A court can find "good cause" only if it determines that the public interest and the need for disclosure outweigh any negative effect the disclosure will have on the client or the doctor–patient or counselor–client relationship and on the effectiveness of the program's treatment services. Before it may issue an order, the court also must find that other ways of obtaining the information are not available or would be ineffective (§2.64(d)). The judge may examine the records before making a decision (§2.64(c).

The scope of the disclosure a court may authorize is limited as well, even when the court finds good cause. The disclosure must be limited to information essential to fulfill the purpose of the order, and it must be restricted to those persons who need the information for that purpose. The court also should take any other steps necessary to protect the client's confidentiality, including sealing court records from public scrutiny (§2.64(e)). The court may order disclosure of "confidential communications" by a client to the program only if the disclosure is:

- Necessary to protect against a threat to life or of serious bodily injury
- Necessary to investigate or prosecute an extremely serious crime (including child abuse)
- Connected with a proceeding at which the client has already presented evidence concerning confidential communications (for example, "I told my counselor…") (§2.63)

These standards govern any effort by CPS agencies to obtain information from a program. However, if the information is sought not by CPS, but by law enforcement authorities to investigate or prosecute a client for a crime, the court must make these additional findings:

- The crime involved is extremely serious, such as an act causing or threatening to cause death or serious injury (including child abuse and neglect)
- The records sought are likely to contain information of significance to the investigation or prosecution
- There is no other practical way to obtain the information
- The public interest in disclosure outweighs any actual or potential harm to the client, the doctor–patient relationship, and the ability of the program to provide services to other clients

When law enforcement personnel seek the order, the court also must find that the program had an opportunity to be represented by independent counsel. If the program is a government entity, it *must* be represented by counsel (§2.65(d)).

Sharing Information With an Outside Service Agency

If a program routinely must share certain information with an outside agency that provides services to the program, a qualified service organization agreement (QSOA) can be made. A QSOA is a written agreement between a program and a person (or agency) providing services to the program, in which that person (or agency):

- Acknowledges that in receiving, storing, processing, or otherwise dealing with any client records from the program, he is fully bound by Federal confidentiality regulations
- Promises that, if necessary, he will resist in judicial proceedings any efforts to obtain access to client records except as permitted by these regulations (§§2.11, 2.12(c)(4)).

A sample QSOA is provided in Figure B-3.

A QSOA should be used only when an agency or official outside the program is providing a service to the program itself. One example of a QSOA is an agreement with an attorney who advises and represents the program. This kind of agreement is helpful if a program has a question about making a report to the CPS system, or receives a subpoena or a notice that someone is seeking a court order authorizing the program to disclose records. The attorney is providing a service to the program by advising on whether a child abuse report must be made or how to handle a subpoena. If a QSOA is made with an attorney, the program can disclose the information the attorney needs to provide the advice. In return, the attorney guarantees that he is bound by the Federal regulations and will not disclose information learned from the program unless the disclosure is permitted by the Federal regulations. Without a QSOA, the program might not be able to communicate with an attorney in order to get assistance—unless the client(s) whose records are sought consents. It is not always possible to obtain a client's consent; for example, she might be incarcerated. Of course, the attorney cannot redisclose the information when redisclosure would violate the regulations.

A QSOA is not a substitute for individual consent in other situations. Disclosures under a QSOA must be limited to information needed by others so that the program can function effectively. A QSOA may not be used between different programs providing substance abuse treatment and other services.

Other Exceptions

Several other exceptions deserve brief mention:

- Communications among program staff
- Medical emergency
- Research, audit, and evaluation

Internal program communications

The Federal regulations permit some information to be disclosed to staff within the same program:

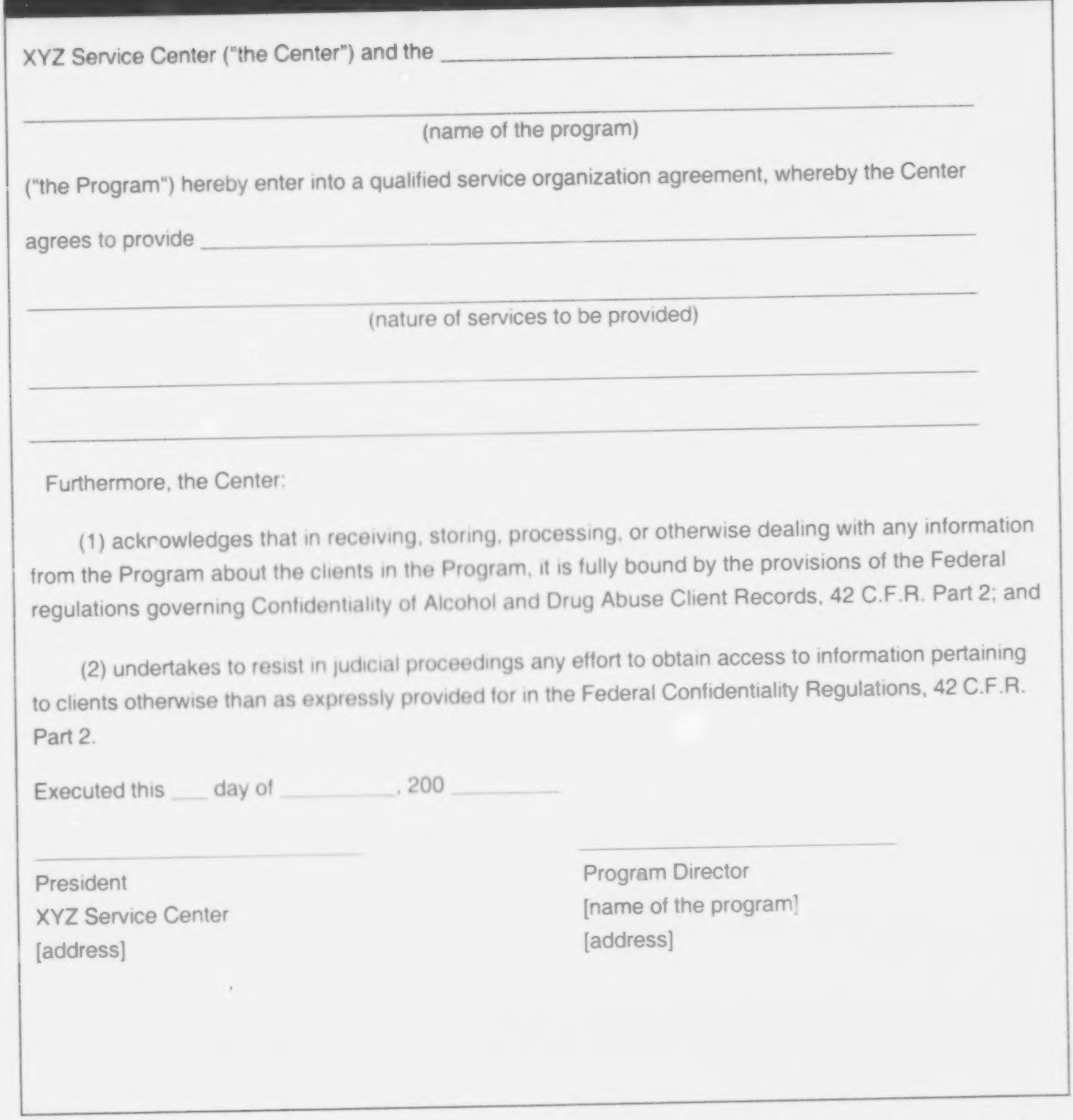
> The restrictions on disclosure in these regulations do not apply to communications of information between or among personnel having a need for the information in connection with their duties that arise out of the provision of diagnosis, treatment, or referral for treatment of substance abuse if the communications are (i) within a program or (ii) between a program and an entity that has direct administrative control over that program (§2.12(c)(3)).

In other words, staff members who have access to client records because they work for or administratively direct the program—including full- or part-time employees and unpaid volunteers—may consult among themselves or otherwise share information if their substance abuse work so requires (§2.12(c)(3)).

Medical emergency

A program may make disclosures to public or private medical personnel "who have a need for

Figure B-3
Qualified Service Organization Agreement



XYZ Service Center ("the Center") and the ________________________________

____
(name of the program)

("the Program") hereby enter into a qualified service organization agreement, whereby the Center

agrees to provide ____

____
(nature of services to be provided)

____

____

Furthermore, the Center:

(1) acknowledges that in receiving, storing, processing, or otherwise dealing with any information from the Program about the clients in the Program, it is fully bound by the provisions of the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Client Records, 42 C.F.R. Part 2; and

(2) undertakes to resist in judicial proceedings any effort to obtain access to information pertaining to clients otherwise than as expressly provided for in the Federal Confidentiality Regulations, 42 C.F.R. Part 2.

Executed this ___ day of _________, 200 ________

____
President
XYZ Service Center
[address]

____
Program Director
[name of the program]
[address]

information about [a client] for the purpose of treating a condition which poses an immediate threat to the health" of the client or any other individual. The regulations define "medical emergency" as a situation that poses an immediate threat to health and requires immediate medical intervention (§2.51).

The medical emergency exception permits disclosure only to medical personnel. This means that the exception cannot be used as the basis for a disclosure to the police or other nonmedical personnel.

Whenever a disclosure is made to cope with a medical emergency, the program must document the following information in the client's records:

- Name and affiliation of the recipient of the information
- Name of the individual making the disclosure
- Date and time of the disclosure
- Nature of the emergency

Research, audit, and evaluation

The confidentiality regulations also permit programs to disclose client-identifying information to researchers, auditors, and evaluators without client consent, provided certain safeguards are met (§§2.52, 2.53).

Other Rules About Clients' Right to Confidentiality

Client Notice and Access to Records

The Federal confidentiality regulations require programs to notify clients of their right to confidentiality and to give them a written summary of the regulations' requirements. The notice and summary should be handed to clients when they begin participating in the program or soon thereafter (§22(a)). The regulations contain a sample notice. Programs can use their own judgment about when to permit clients to view or obtain copies of their records, unless State law allows clients the right of access to records. The Federal regulations do not require programs to obtain written consent from clients before permitting them to see their own records.

Security of Records

The Federal regulations require programs to keep written records in a secure room, locked file cabinet, safe, or other similar container. Programs should establish written procedures that regulate access to and use of clients' records. Either the program director or a single staff person should be designated to process inquiries and requests for information (§2.16). Computerization of records greatly complicates efforts to ensure security. (For a brief discussion of some of the issues computerization raises, see TIP 23, *Treatment Drug Courts: Integrating Substance Abuse Treatment With Legal Case Processing* [CSAT, 1996].)

State Confidentiality Laws

States also have laws limiting what information about clients may be disclosed and how disclosure must be handled. For example, most States have laws that offer some protection to patients' medical information. Clients think of these laws as the "doctor–patient privilege."

Strictly speaking, the doctor–patient privilege is a rule of evidence that governs whether a clinician can be asked or compelled to testify in a court case about a client. In many States, however, laws offer wider protection. Some States have special confidentiality laws that explicitly prohibit certain types of providers from divulging information about clients without consent. States often include such prohibitions in professional licensing laws, which generally prohibit licensed professionals from divulging information about clients and make unauthorized disclosures grounds for disciplinary action, including license revocation.

Each State has its own set of rules, which means that the scope of protection offered by State law varies widely. Whether a communication (or laboratory test result) is "privileged" or "protected" may depend on a number of factors:

- The type of professional holding the information and whether he is licensed or certified by the State
- The context in which the information was communicated to or obtained by the professional
- The context in which the information will be or was disclosed

- Exceptions to any general rule protecting information
- How the protection is enforced

Conclusion

To be effective in treating clients with substance abuse disorders, counselors must respect their clients' right to confidentiality. With the complex layering of Federal and State rules concerning confidentiality, how does a counselor avoid violating the rules—short of hiring a lawyer? When in doubt, counselors usually can follow these simple rules: (1) consult the client—making clear the options, as well as the counselor's legal obligations, (2) be sensitive to what information is disclosed and how, and (3) review the case with a clinical supervisor. Only as a last resort should the counselor have to consult State law or a lawyer.

Appendix C

Implications of Recent Federal Legislation for Clients in Treatment

The following brief review summarizes the recent Federal legislation mentioned in Chapter 7 that will have an impact on substance abuse treatment, especially for clients involved in the child protective services (CPS) system.

Welfare Reform

Provisions of the Personal Responsibility and Work Opportunity Reconciliation Act (1996) will affect all parents receiving public assistance, including those in substance abuse treatment. However, because the law is fairly new and each State has some choice in the way it implements the law, it is difficult to forecast precisely who will be affected and how. With that caveat, here are a number of issues to keep in mind:

1. *Mandatory work requirements*: States must move increasing numbers of people from welfare to work or face a reduction in Federal funding. With few exceptions, recipients must work after 2 years of receiving public assistance. Parents in treatment who fail to comply with the work requirements will see their benefits reduced or eliminated. (States may not penalize single parents with a child under 6 who cannot find child care.) States may also cut Medicaid coverage to parents who do not comply with the work requirement (42 U.S.C. §607(e)).
2. *Time limits*: No family may receive assistance for more than 5 cumulative years (or a lesser period of time, at the State's option). Once a parent has been on public assistance the allotted time, he may be cut from the rolls, although certain hardship exceptions can be made (42 U.S.C. §608(a)(7)).
3. *Drug testing*: States may screen welfare recipients for substance use and sanction those who test positive by reducing or eliminating their benefits or mandating treatment.
4. *Drug felony ban*: Those applying for public assistance must disclose any substance-related conviction of any household member. States then can deny public assistance and food stamps to individuals whose substance felony convictions occurred after August 22, 1996. States must take an affirmative step to opt out of this ban (§115 of P.L. 104-193, as amended by §5516 of P.L. 105-33).

5. *Probation/parole violation ban:* Offenders who violate the terms of their probation or parole lose their public assistance and food stamps. In some States, offenders who have been mandated into treatment and who leave treatment may be subject to this provision (42 U.S.C. §608(a)(9)).
6. *Restrictions on immigrants:* A lawful immigrant may or may not be eligible for benefits, depending on a variety of factors, including the benefit he applies for (e.g., Medicaid, food stamps, or public assistance), when he arrived in this country, how long he has been here, his age, and other facts about his personal history.

Family Preservation and "Fast-Track" Adoption

The Federal government has established a series of programs to fund and support States' efforts to help children and their families in crisis. These programs include the following:

- *Family Support Services*, which are "community-based services to promote the safety and well-being of children and families designed to increase the strength and stability of families (including adoptive, foster, and extended families), to increase parents' confidence and competence in their parenting abilities, to afford children safe, stable, and supportive family environments, and otherwise to enhance child development" (42 U.S.C. §629a(2), as amended by §305 of the Adoption and Safe Families Act of 1997)
- *Family Preservation Services*, which include
  - Preplacement preventive services, such as intensive family preservation programs, to help children at risk of foster care placement remain safely with their families (42 U.S.C. §629a(a)(1), as amended by §305 of the Adoption and Safe Families Act of 1997)
  - "Time-limited family reunification services … provided to a child who is removed from the … home and placed in a foster family home or a child care institution and to the parents or primary caregiver of such a child, … to facilitate the reunification of the child safely and appropriately" (42 U.S.C. §629a(a)7, as amended by §305 of the Adoption and Safe Families Act of 1997)
  - Programs to provide followup care to families when a child has been returned after a foster care placement (42 U.S.C. §629a(1), as amended by §305 of the Adoption and Safe Families Act of 1997)
- *Foster Care Services*, which assist States with foster care maintenance payments (42 U.S.C. §670)
- *Adoption Promotion and Support Services* to encourage more adoptions out of the foster care system, when such adoptions promote the best interests of children. These services include
  - Pre- and postadoptive services
  - Services to expedite the adoption process and support adoptive families
  - Adoption incentive payments (42 U.S.C. §673(a)(1)(A) and §673A, as amended by §201 of the Adoption and Safe Families Act of 1997)

These programs provide funding to States but also require States to adopt a number of important policies, timetables, and restrictions, including

- *Greater emphasis on children's health and safety:* Until recently, Federal law has placed primary emphasis on preservation of the family—that is, avoiding foster care placement whenever possible and encouraging the speedy return of children to their families. In line with that policy, since 1983, States have been required to maintain a federally approved plan that ensures that "reasonable efforts" will be made to prevent or eliminate the need for a child to be removed from the home and placed in foster care and to make it possible for the child to return to the home. The 1997 amendments to the Family Preservation and Support Services Act changed the emphasis from family preservation to child health and safety by adding the following:

> In determining reasonable efforts to be made with respect to a child ... and in making such reasonable efforts, the child's health and safety shall be the paramount concern (42 U.S.C. §671(a)(15), as amended by §101 of the Adoption and Safe Families Act of 1997).

- *Greater emphasis on permanent placement*: The 1997 Act requires each State's federally approved plan to promote the permanent placement of children:

> ... if continuation of reasonable efforts [to preserve or reunite the family] ... is ... inconsistent with the permanency plan for the child, reasonable efforts shall be made to place the child in a timely manner in accordance with the permanency plan, and to complete whatever steps are necessary to finalize the permanent placement of the child (42 U.S.C. §671(a)(15), as amended by §101 of the Adoption and Safe Families Act of 1997).

Moreover, to reduce the numbers of children who remain in foster care for years and increase the number of children who are more promptly settled into a permanent living situation, the 1997 Act provides that States "shall not be required" to make reasonable efforts to preserve or reunify a family when

- A parent has subjected the child to "aggravated circumstances" as defined by State law (including abandonment, torture, and sexual abuse)
- A parent has committed murder or involuntary manslaughter against another of her children or felony assault resulting in serious bodily injury to the child or a sibling
- Parental rights have been terminated with regard to a sibling (42 U.S.C. §671(a)(15), as amended by §101 of the Adoption and Safe Families Act of 1997)

- *Prompt development and frequent review of service plans*: Within 60 days of beginning services to families, the agency charged with responsibility must develop a case or service plan for each child. Each child's status must be reviewed at least once every 6 months by a court or administrative agency to decide whether placement continues to be necessary and appropriate (42 U.S.C. §675(5), as amended by §103 of the Adoption and Safe Families Act of 1997).
- *Time limits on family reunification services*: Family reunification services are now limited to 15 months after the child has been removed from the family and placed in foster care. This time limit applies to substance abuse treatment and mental health services; individual, group, or family counseling; and transportation to or from services (42 U.S.C. §675(5), as amended by §§103 and 305 of the Adoption and Safe Families Act of 1997).
- *Speedier termination of parental rights*: To reduce the number of children who remain in foster care for years and to increase the number of children who are more promptly settled into a permanent living situation, the State must
  - Hold a "permanency" hearing (formerly called a "dispositional" hearing) within 12 months of the child's placement to determine whether to return the child, initiate termination proceedings, or place the child in another permanent living arrangement (42 U.S.C. §675(5)(c)), as amended by §302 of the Adoption and Safe Families Act of 1997)

- Begin the process of terminating parental rights, with certain exceptions, and finding permanent adoptive or legal guardianship homes for children who have been in foster care for 15 of the most recent 22 months (42 U.S.C. §675(5)(c)), as amended by §103 of the Adoption and Safe Families Act of 1997)
- Commence termination proceedings within 30 days when a child is placed in foster care and the State declines to offer family preservation or reunification services because (1) the parent subjected the child to "aggravated circumstances" as defined by State law; (2) the parent committed murder or voluntary manslaughter against another of his children; (3) the parent committed felony assault resulting in serious bodily injury to the child or another of his children; or (4) parental rights have been terminated involuntarily with regard to a sibling (42 U.S.C. §671(a)(15), "the Family Preservation and Support Services Act," now called "Promoting Safe and Stable Families," as amended by §101 of the Adoption and Safe Families Act of 1997 and 42 U.S.C. §475(5), as amended by §103 of the Adoption and Safe Families Act of 1997)
- Document in the case plan the steps being taken to secure a permanent home for the child when the permanency plan is adoption or placement in another kind of permanent home (42 U.S.C. §675(1), as amended by §107 of the Adoption and Safe Families Act of 1997)

- *Adoption incentive payments*: The Federal Adoption Assistance Program assists States in providing nonrecurring adoption expenses (such as adoption fees, court costs, and attorneys' fees) and ongoing assistance to families adopting children out of foster care. The Adoption and Safe Families Act of 1997 requires States to submit an annual report on performance in increasing adoptions from foster care and empowers the Secretary of Health and Human Services to provide incentive payments to States that increase adoptions from foster care (42 U.S.C. §473, as amended by §§201 and 402 of the Adoption and Safe Families Act of 1997).

Appendix D
Obtaining Screening and Assessment Tools

Addiction Severity Index
National Technical Information
Service Order Desk
5285 Port Royal Road
Springfield, VA 22161
Phone: (888) 584-8332
Fax: (703) 605-6900
Email: info@ntis.fedworld.gov
Web site: http://www.ntis.gov

Beck Depression Inventory
The Psychological Corporation
555 Academic Court
San Antonio, TX 78204-3956
Phone: (800) 622-3231
Email: Customer_Service@hbtpc.com
Web site: http://www.hbtpc.com

Brief Symptom Inventory
NCS Assessment
P.O. Box 1416
Minneapolis, MN 55440
Phone: (800) 627-7271
Email: assessments@ncs.com
Web site: http://www.ncs.com

Childhood Maltreatment Interview Schedule
John Briere, Ph.D.
Department of Psychiatry and Behavioral
Sciences
University of Southern California
School of Medicine
1937 Hospital Place
Los Angeles, CA 90033
Phone: (213) 226-5697
Email: jbriere@hsc.usc.edu

Childhood Trauma Interview
Laura Fink, Ph.D.
c/o Josephine Dodge
Bronx VA Medical Center
Psychiatry Service 116A
130 West Kingsbridge Road
Bronx, NY 10468
Phone: (718) 584-9000 x 6990
Email: dodge.j@bronx.va.gov

Childhood Trauma Questionnaire
NCS Assessment
P.O. Box 1416
Minneapolis, MN 55440
Phone: (800) 627-7271
Email: assessments@ncs.com
Web site: http://www.ncs.com

Clinician-Administered PTSD Scale
Frank W. Weathers, Ph.D.
National Center for PTSD
Boston VA Medical Center (116B)
150 South Huntington Avenue
Boston, MA 02130
Phone: (617) 232-9500
Email:ptsd@dartmouth.edu
Web site: http//www.dartmouth.edu/dms/ptsd

Diagnostic Interview Schedule
Lee Robins, Ph.D.
Department of Psychiatry, Box 8134
Washington University School of Medicine
4940 Children's Place
St. Louis, MO 63110
Phone: (314) 362-2469
Email: robins@epi.wustl.edu

Dissociative Experiences Scale
The Sidran Foundation
2328 West Joppa Road, Suite 15
Lutherville, MD 21093
Phone: (410) 825-8888
Email: sidran@sidran.org
Web site: http://www.sidran.org

Evaluation of Lifetime Stressors (Test #2)
Karen Krinsley, Ph.D.
National Center for PTSD (116B-2)
Boston VA Medical Center
150 South Huntington Avenue
Boston, MA 02130
Phone: (617) 232-9500
Email: ptsd@dartmouth.edu
Web site: http//www.dartmouth.edu/dms/ptsd

MINI International Neuropsychiatric Interview
Medical Outcome Systems
10440 Rolling Brook Court
Jacksonville, FL 32256
Phone: (904) 363-6246
Email: questions@medical-outcomes.com
Web site: http://www.medical-outcomes.com

Modified PTSD Symptom Scale: Self-Report Version
Sherry Falsetti, Ph.D.
National Crime Victims Research and Treatment Center
Department of Psychiatry and Behavioral Sciences
Medical University of South Carolina
171 Ashley Avenue
Charleston, SC 29425-0742
Phone: (803) 792-2945
Email: falseta@musc.edu
Web site: http://www.musc.edu/cvc

National Women's Study Event History
Dean Kilpatrick, Ph.D.
National Crime Victims Research and Treatment Center
Department of Psychiatry and Behavioral Sciences
Medical University of South Carolina
171 Ashley Avenue
Charleston, SC 29425-0742
Phone: (803) 792-2945
Email: kilptg@musc.edu
Web site: http://www.musc.edu/cvc

Parent-Child Relationship Inventory (PCRI)
University of Nebraska Press
P.O. Box 880484
312 N. 14th Street
Lincoln, NE 68588-0484
Phone: (800) 755-1105
FAX: (800) 526-2617
Web site: http://www.unl.edu/buros/13tests.html

Parental Acceptance and Rejection Questionnaire (PARQ)
Handbook for the Study of Parental Acceptance and Rejection
Center for the Study of Parental Acceptance and Rejection
University of Connecticut
Storrs, CT 06269
(860) 486-0073
Email: rohner@uconnvm.uconn.edu
Web site: http://vm.uconn.edu/~rohner/

Penn Inventory for Posttraumatic Stress Disorder
Melvyn Hammarberg, Ph.D.
Department of Anthropology
University of Pennsylvania
325 University Museum
Philadelphia, PA 19104-6398
Phone: (215) 898-0981
Email: mhammarb@ccat.sas.upenn.edu
Web site: http://www.sas.upenn.edu/anthro/faculty/profiles/hammarberg.html

Posttraumatic Stress Diagnostic Scale
NCS Assessment
P.O. Box 1416
Minneapolis, MN 55440
Phone: (800) 627-7271
Email: assessments@ncs.com
Web site: http://www.ncs.com

Profile of Mood States
Educational and Industrial Testing Service
P.O. Box 7234
San Diego, CA 92167
Phone: (800) 416-1666
Email: edits@worldnet.att.net
Web site: http://www.edits.net

Psychiatric Research Interview for Substance and Mental Health Disorders
Deborah Hasin, Ph.D.
Research Assessment and Training
New York State Psychiatric Institute
722 West 168th Street
New York, NY 10032
Phone: (212) 543-5000
Email: hasind@nypdrat.cpmc.columbia.edu
Web site: http://nyspi.cpmc.columbia.edu

Schedule for Affective Disorders and Schizophrenia
Jean Endicott, Ph.D.
Research Assessment and Training
New York State Psychiatric Institute
722 West 168th Street
New York, NY 10032
Phone: (212) 543-5000
Email: je10@columbia.edu
Web site: http://nyspi.cpmc.columbia.edu

Screen for Posttraumatic Stress Symptoms
Eve Carlson, Ph.D.
Clinical Psychology Associates
611 East Walworth Avenue
Delavan, WI 53115
Phone: (414) 740-9191

Structured Clinical Interview for DSM-IV Axis I Disorders
American Psychiatric Press, Inc.
1400 K Street, N.W.
Washington, DC 20005
Phone: (800) 369-5777
Email: csdept@appi.org
Web site: http://www.appi.org

Symptom Checklist-90-Revised
NCS Assessment
P.O. Box 1416
Minneapolis, MN 55440
Phone: (800) 627-7271
Email: assessments@ncs.com
Web site: http://www.ncs.com

Trauma Assessment for Adults (TAA)-Self-Report
Heidi Resnick, Ph.D.
National Crime Victims Research and Treatment Center
Department of Psychiatry and Behavioral Sciences
Medical University of South Carolina
171 Ashley Avenue
Charleston, SC 29425-0742
Phone: (803) 792-2945
Email: resnickh@musc.edu
Web site: http://www.musc.edu/cvc

Trauma Symptom Checklist-40
John Briere, Ph.D.
Department of Psychiatry and Behavioral Sciences
University of Southern California
School of Medicine
1937 Hospital Place
Los Angeles, CA 90033
Phone: (213) 226-5697
Email: jbriere@hsc.usc.edu

Trauma Symptom Inventory
Psychological Assessment Resources, Inc.
P.O. Box 998
Odessa, FL 33556
Phone: (800) 331-8378
Email: custserv@parinc.com
Web site: http://www.parinc.com

Appendix E

Resources Related to Childhood Trauma Among Adults

The following entries represent a range of resources, consultation, and expertise related to childhood abuse and neglect. Many of these can provide in-service training, targeted consultation for individual clients, or ongoing expertise with regard to screening, assessment, treatment, and referral of adults with histories of childhood trauma.

Associations and Societies

American Academy of Pediatrics
141 Northwest Point Boulevard
P.O. Box 927
Elk Grove Village, IL 60009-0927
Phone: (708) 228-5005
Fax: (708) 228-5097
Web site: http://www.aap.org

American Bar Association
Center on Children and the Law
1800 M Street, NW, Suite 200
Washington, DC 20036
Phone: (202) 331-2250
Email: ctrchildlaw@abanet.org
Web site: http://www.abanet.org/child /home

American Professional Society on Abuse and Children
332 South Michigan Avenue, Suite 1600
Chicago, IL 60604
Phone: (312) 554-0166
Email: APSACMems@aol.com
Web site: http://www.apsac.org

American Psychiatric Association
1400 K Street, NW
Washington, DC 20005
Phone: (202) 682-6083
Fax: (202) 682-6353
Email: apa@psych.org
Web site: http://www.psych.org

American Psychological Association
750 First Street, NE
Washington, DC 20002-4242
Phone: (202) 336-5500
Fax: (202) 336-6080
Email: rdf.apa@email.apa.org
Web site: http://www.apa.org

American Public Human Services Association
810 First Street, NE, Suite 500
Washington, DC 20002
Phone: (202) 682-0100
Web site: http://www.aphsa.org

American Society of Addiction Medicine
Arcade, Suite 101
4601 North Park Avenue
Chevy Chase, MD 20815
Phone: (301) 656-3920
Fax: (301) 656-3815
Web site: http://www.asam.org

Child Welfare League of America
440 First Street, NW, 3rd Floor
Washington, DC 20001
Phone: (202) 638-2952
Fax: (202) 638-4004
Web site: http://www.cwla.org

The International Society for the Prevention of Child Abuse and Neglect
401 North Michigan Avenue, Suite 2200
Chicago, IL 60611
Phone: (312) 644-6610, ext. 3273
Email: kim_svevo@sba.com
Web site: http://child.cornell.edu/

International Society for Traumatic Stress Studies
60 Revere Drive, Suite 500
Northbrook, IL 60062
Phone: (847) 480-9028
Email: istss@istss.com
Web site: http://www.istss.com

International Society for the Study of Dissociation
60 Revere Drive, Suite 500
Northbrook, IL 60062
Phone: (847) 480-0899
Fax: (847) 480-9282
Web site: http://www.issd.org

National Mental Health Association
1201 Prince Street
Alexandria, VA 22314-2971
Phone: (703) 684-7722
Web site: http://www.nmha.org

Organizations and Clearinghouses

Local crisis lines often have referrals to local organizations.

Anxiety Disorders Association of America
6000 Executive Boulevard, Department A
Rockville, MD 20852
Phone: (301) 231-9350
Email: anxdis@aol.com
Web site: http://www.adaa.org

Center for the Prevention of Sexual and Domestic Violence
936 North 34th Street, Suite 200
Seattle, WA 98103
Phone: (206) 634-1903
Email: cpsdv@cpsdv.seanet.com
Web site: http://www.cpsdv.org

Domestic Violence Training Project
900 State Street
New Haven, CT 06511
Phone: (203) 865-3699

Family Violence and Sexual Assault Institute
1121 ESE Loop 323, Suite 130
Tyler, TX 75701
Phone: (903) 534-5100
Email: fvsai@iamerica.net
Web site: http://www.gatekeep.net/fvsai/index.html

National Abandoned Infants Assistance Resource Center
1950 Addison Street, Suite 104
Berkeley, CA 94704-1182
Phone: (510) 643-7020
Fax: (510) 643-7019

National Alliance for the Mentally Ill
200 North Glebe Road, Suite 1015
Arlington, VA 22203-3754
Phone: (800) 950-6264
Web site: http://www.nami.org

National Center on Child Abuse and Neglect
P.O. Box 1182
Washington, DC 20013
Phone: (703) 385-7565
Email: nccanch@calib.com
Web site: http://www.calib.com/nccanch

National Center for PTSD
VA Medical Center (116D)
White River Junction, VT 05009
Phone: (802) 296-5132
Email: ptsd@dartmouth.edu
Web site: http://www.dartmouth.edu/dms/ptsd

National Clearinghouse on Child Abuse and Neglect Information
P.O. Box 1182
Washington, DC 20013-1182
Phone: (800) FYI-3366
Email: nccanch@calib.com
Web site: http://www.calib.com/nccanch

National Coalition Against Domestic Violence
P.O. Box 18749
Denver, CO 80218
Phone: (303) 839-1852
Web site: http//www.webmerchants.com/ncadv

National Committee to Prevent Child Abuse
P.O. Box 2866
Chicago, IL 60690-9950
[or] 200 South Michigan Avenue, 17th Floor
Chicago, IL 60604-2404
Phone: (800) CHILDREN, or (312) 663-3520
Fax: (312) 939-8962
Email: ncpca@childabuse.org
Web site: http//www.childabuse.org

National Mental Health Consumers' Self-Help Clearinghouse
1211 Chestnut Street
Philadelphia, PA 19107
Phone: (800) 553-4539
Email mhselfhelp@libertynet.org
Web site: http://www.mhselfhelp.org

National Children's Advocacy Center
200 Westside Square, Suite 700
Huntsville, AL 35801
Phone: (256) 533-0531
Fax: (256) 534-6883
Email: webmaster@ncac-hsv.org
Web site: http://ncac-hsv.org

National Victim Center Infolink
Phone: (800) FYI-CALL
Phone: (703) 276-2880
Web site: http://www.nvc.org

One Voice/The National Coalition for Abuse Awareness
P.O. Box 27958
Washington, DC 20038-7958
Phone: (202) 462-4688 or (202) 667-1160 (resource line)
Fax (202) 462-4689
Email: Ovicedc@aol.com or ACAADC@aol.com

The Sidran Foundation
2328 West Joppa Road, Suite 15
Lutherville, MD 21093
Phone: (410) 825-8888
Email: sidran@sidran.org
Web site: http://www.sidran.org

Zero to Three
National Center for Infants, Toddlers, and Families
734 Fifteenth Street, NW
Suite 1000
Washington, D.C. 20005-1013
Phone: (202) 638-1144
FAX: (202) 638-0851
Web site: www.zerotothree.org

Publications

Moving Forward
(A semi-annual newsletter for survivors of childhood sexual abuse)
P.O. Box 4426
Arlington, VA 22204
Phone: (703) 271-4024

Once Upon a Time: Therapeutic Stories To Heal Abused Children
Nancy Davis, Ph.D.
6178 Oxon Hill Rd.
Suite 306
Oxon Hill, MD 20745
Phone: (301) 567-9297

Appendix F
Resource Panelists

Cheryl A. Boyce, Ph.D.
Developmental Psychology
Society for Research in Child Development
Rockville, Maryland

Jutta H. Butler
Public Health Advisor
Systems Improvement Branch
Division of National Treatment Demonstrations
Center for Substance Abuse Treatment
Rockville, Maryland

Peter J. Cohen, M.D., J.D.
Visiting Professor of Law
Georgetown University
Washington, D.C.

Michael D. De Bellis, M.D.
Assistant Professor of Psychiatry
Developmental Traumatology Laboratory
University of Pittsburgh Medical Center
Pittsburgh, Pennsylvania

Deborah Duran, Ph.D.
Research and Policy
National Coalition of Hispanic Health
Washington, D.C.

Laura Feig, M.P.P.
Social Science Analyst
Division of Children and Youth Policy
Office of the Assistant Secretary for Planning and Evaluation
Department of Health and Human Services
Washington, D.C.

Loretta Finnegan, M.D.
Office of the Director
Center for Substance Abuse Treatment
Rockville, Maryland

Malcolm Gordon, Ph.D.
Chief
Child Trauma and Victimization Program
Developmental Psychology Research Branch
National Institute of Mental Health
Rockville, Maryland

Helen Howerton, M.A.
Director
Child and Family Development
Office of Planning, Research, and Evaluation
Administration for Children and Families
Washington, D.C.

Jenny Collier McColl
Legislative Counsel
Legal Action Center
Washington, D.C.

Lynn Moore
Program Specialist
National Clearinghouse on Child Abuse and Neglect Information
Fairfax, Virginia

Hector Sanchez
Public Health Advisor
Division of State and Community Assistance
Center for Substance Abuse Treatment
Rockville, Maryland

Elizabeth Sloan, L.P.C.
Director
Clinical Affairs
American Academy of Child and Adolescent Psychiatry
Washington, D.C.

Richard T. Suchinsky, M.D.
Associate Chief for Addictive Disorders and Psychiatric Rehabilitation
Mental Health and Behavioral Sciences Services
Department of Veterans Affairs
Washington, D.C.

Appendix G
Field Reviewers

Judith A. Arroyo, Ph.D.
Coordinator
Project COMBINE
University of New Mexico
Center on Alcoholism, Substance Abuse and Addictions
Albuquerque, New Mexico

Eileen Bagus, M.A., M.S.W., L.S.W., Ph.D.
Clinical Service Provider
Adult Services
Talbert House
Cincinnati, Ohio

Rodolfo Briseno, L.C.D.C.
Coordinator for Cultural/Special Populations and Youth Treatment
Program Services, Program Initiatives
Texas Commission on Alcohol and Drug Abuse
Austin, Texas

Brenda F. Carlin
President/Founder
Survivors Unlimited, Inc.
Sulphur, Lousiana

Candace R. Charkow
Treatment Program Manager
Division of Family Services
Department of Services for Children, Youth, and Their Families
Wilmington, Delaware

Dorynne Czechowicz, M.D.
Associate Director
Division of Clinical and Services Research
Treatment Research Branch
National Institute on Drug Abuse
Bethesda, Maryland

Elaine Engelsted, J.D., C.S.A.C.
Writer
Kailua Kona, Hawaii

Gary L. Fisher, Ph.D.
Nevada Addiction Technology Transfer Center
College of Education
University of Nevada at Reno
Reno, Nevada

Cynthia Flackus, M.S.W., L.I.C.S.W.
Therapist
CAMP SHARE
Renewal Center
Walker, Minnesota

Linda E. Friedman, Ed.D., L.P.C.C., M.A.
Clinical Counselor
Treatment Division
University of New Mexico
Center on Alcoholism, Substance Abuse and Addictions
Albuquerque, New Mexico

Esther Giller, M.A.
President and Director
Sidran Foundation and Press
Lutherville, Maryland

Karol A. Kaltenbach, Ph.D.
Clinical Associate Professor of Pediatrics, Psychiatry and Human Behavior
Director
Maternal Addiction: Treatment Education and Research (MATER)
Department of Pediatrics
Jefferson Medical College
Philadelphia, Pennsylvania

Loretta Kowal, L.I.C.S.W.
Wabon, Massachusetts

Martha Kurgans, M.A.
Assistant Professor
Department of Psychiatry
Division of Addictive Medicine
Virginia Commonwealth University
Medical College of Virginia Hospital
Richmond, Virginia

Kerry Locklear, L.C.S.W., M.S.W.
Private Practitioner, Child Protective Services Worker
Family Youth and Children
Sonoma County Human Services Department
Santa Rosa, California

Russell P. MacPherson, Ph.D., C.A.P., C.A.P.P., C.C.P., D.A.C., D.V.C.
President
RPM Addiction Prevention Training
Deland, Florida

Susan E. Martin, Ph.D.
Program Manager
Prevention Research Branch
National Institute on Alcohol and Alcoholism
Rockville, Maryland

Catherine McAlpine, Ph.D., L.C.S.W.-C, M.S.W.
Clinical Supervisor
Adult Addiction Services
Montgomery County Department of Health and Human Services
Rockville, Maryland

Martha A. Medrano, M.D., M.P.H.
Assistant Professor
Health Science Center at San Antonio Medical School
Department of Psychiatry
The University of Texas
San Antonio, Texas

Thomas Nicholson, Ph.D, M.P.H., M.A.Ed.
Professor
Department of Public Health
Western Kentucky University
Bowling Green, Kentucky

Patricia A. Paluzzi, C.N.M., M.P.H.
Associate Medical Director
Clinical Services
Planned Parenthood of Maryland
Baltimore, Maryland

Peter Panzarella, M.A., M.S.
Director of Substance Abuse Services
Health Management
Department of Children and Families
Hartford, Connecticut

Scott M. Reiner, M.S., C.A.C., C.C.S.
Substance Abuse Program Supervisor
Substance Abuse Services Unit
Virginia Department of Juvenile Justice
Richmond, Virginia

Margaret M. Salinger, M.S.N., R.N., C.A.R.N.
Audubon, Pennsylvania

Lois D. Sharp, M.S.
Doctoral Candidate
Palo Alto VA Health Care System
National Center for PSTD and Pacific Graduate School of Psychology
Palo Alto, California

Tracy Lynn Simpson, M.S.
Seattle, Washington

Christine Smith, M.S.W.
Senior Analyst
ABT Associates
Cambridge, Massachusetts

Richard T. Suchinsky, M.D.
Associate Chief for Addictive Disorders and Psychiatric Rehabilitation
Mental Health and Behavioral Sciences Services
Department of Veterans Affairs
Washington, D.C.

Nancy E. Suchman, Ph.D.
Associate Research Scientist
Child and Family Research
Yale University School of Medicine
New Haven, Connecticut

Pamela Valentine, Ph.D., M.S.W.
Assistant Professor
Department of Government and Public Service–Social Work Program
School of Social and Behavioral Sciences
University of Alabama at Birmingham
Birmingham, Alabama

Charles L. Whitfield, M.D.
Atlanta, Georgia

Katherine Wingfield, M.S.W.
Program Manager
Chemical Dependency Initiative
Child Welfare League of America
Washington, D.C.

The TIPs Series

TIP 1	*State Methadone Treatment Guidelines* **BKD98**
TIP 2	*Pregnant, Substance-Using Women* **BKD107**
TIP 3	*Screening and Assessment of Alcohol- and Other Drug-Abusing Adolescents* **BKD108**
TIP 4	*Guidelines for the Treatment of Alcohol- and Other Drug-Abusing Adolescents* **BKD109**
TIP 5	*Improving Treatment for Drug-Exposed Infants* **BKD110**
TIP 6	*Screening for Infectious Diseases Among Substance Abusers* **BKD131**
TIP 7	*Screening and Assessment for Alcohol and Other Drug Abuse Among Adults in the Criminal Justice System* **BKD138**
TIP 8	*Intensive Outpatient Treatment for Alcohol and Other Drug Abuse* **BKD139**
TIP 9	*Assessment and Treatment of Patients With Coexisting Mental Illness and Alcohol and Other Drug Abuse* **BKD134**
TIP 10	*Assessment and Treatment of Cocaine-Abusing Methadone-Maintained Patients* **BKD157**
TIP 11	*Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases* **BKD143**
TIP 12	*Combining Substance Abuse Treatment With Intermediate Sanctions for Adults in the Criminal Justice System* **BKD144**
TIP 13	*The Role and Current Status of Patient Placement Criteria in the Treatment of Substance Use Disorders* **BKD161**
TIP 14	*Developing State Outcomes Monitoring Systems for Alcohol and Other Drug Abuse Treatment* **BKD162**
TIP 15	*Treatment for HIV-Infected Alcohol and Other Drug Abusers* **BKD163**
TIP 16	*Alcohol and Other Drug Screening of Hospitalized Trauma Patients* **BKD164**
TIP 17	*Planning for Alcohol and Other Drug Abuse Treatment for Adults in the Criminal Justice System* **BKD165**
TIP 18	*The Tuberculosis Epidemic: Legal and Ethical Issues for Alcohol and Other Drug Abuse Treatment Providers* **BKD173**
TIP 19	*Detoxification From Alcohol and Other Drugs* **BKD172**
TIP 20	*Matching Treatment to Patient Needs in Opioid Substitution Therapy* **BKD168**
TIP 21	*Combining Alcohol and Other Drug Abuse Treatment With Diversion for Juveniles in the Justice System* **BKD169**
TIP 22	*LAAM in the Treatment of Opiate Addiction* **BKD170**
TIP 23	*Treatment Drug Courts: Integrating Substance Abuse Treatment With Legal Case Processing* **BKD205**
TIP 24	*A Guide to Substance Abuse Services for Primary Care Clinicians* **BKD234**
TIP 25	*Substance Abuse Treatment and Domestic Violence* **BKD239**
TIP 26	*Substance Abuse Among Older Adults* **BKD250**
TIP 27	*Comprehensive Case Management for Substance Abuse Treatment* **BKD251**
TIP 28	*Naltrexone and Alcoholism Treatment* **BKD268**
TIP 29	*Substance Use Disorder Treatment for People With Physical and Cognitive Disabilities* **BKD288**
TIP 30	*Continuity of Offender Treatment for Substance Use Disorders From Institution to Community* **BKD304**
TIP 31	*Screening and Assessing Adolescents for Substance Use Disorders* **BKD306**
TIP 32	*Treatment of Adolescents With Substance Use Disorders* **BKD307**
TIP 33	*Treatment for Stimulant Use Disorders* **BKD289**
TIP 34	*Brief Interventions and Brief Therapies for Substance Abuse* **BKD341**
TIP 35	*Enhancing Motivation for Change in Substance Abuse Treatment* **BKD342**
TIP 36	*Substance Abuse Treatment for Persons With Child Abuse and Neglect Issues* **BKD343**

Other TIPs may be ordered by contacting the National Clearinghouse for Alcohol and Drug Information (NCADI), (800) 729-6686 or (301) 468-2600; TDD (for hearing impaired), (800) 487-4889.

DHHS Publication No. (SMA) 00-3357
Substance Abuse and Mental Health Services Administration
Printed 2000

SAMHSA